HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
AUGUST 24, 2016
APPLICATION SUMMARY

NAME OF PROJECT:	Erlanger Behavioral Health, LLC
PROJECT NUMBER:	CN1603-012
ADDRESS:	Intersection of North Holtzclaw Avenue and Citico Avenue Chattanooga, TN (Hamilton County), TN 37404
LEGAL OWNER:	Erlanger Behavioral Health, LLC 975 East 3rd Street Chattanooga, TN 37403
OPERATING ENTITY:	N/A
CONTACT PERSON:	Joseph Winick (423) 778-8088
DATE FILED:	March 15, 2016
PROJECT COST:	$25,112,600
FINANCING:	Commercial Loan
REASON FOR FILING:	Establishment of a new eighty-eight (88) bed mental health hospital and initiation of inpatient psychiatric and substance abuse services

DESCRIPTION:

Erlanger Behavioral Health, LLC proposes to construct a new 88 inpatient licensed bed psychiatric hospital located at the intersection of North Holtzclaw Avenue and Citico Avenue, Chattanooga (Hamilton County), TN. If approved, Erlanger Behavioral Health's 88 licensed beds will consist of the following inpatient units: adult (24 beds); geriatric (24 beds); children and adolescent (18 beds); and adult chemical dependency services (22 beds). The applicant proposes

to also provide psychiatric partial hospitalization and outpatient care, as well as crisis assessments and intakes for patients on an emergency basis, if needed.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW:

Psychiatric Inpatient Services

A. Need

1. The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of Health and applying the data in Joint Annual Reports).

See below

2. For adult programs, the age group of 18 years and older should be used in calculating the estimated total number of beds needed.

2016 Population-Service Area (TN Counties)

Age 0-17	*215,353*	*X*	*30 beds/100,000= 64.6 beds*
Age 18-64	*596,632*	*X*	*30 beds/100,000= 179.0 beds*
Age 65+	*233,652*	*X*	*30 beds/100,000 = 61.0 beds*
			Total=304.6 beds

2020 Population-Service Area (TN Counties)

Age 0-17	*217,133*	*X*	*30 beds/100,000= 65.1 beds*
Age 18-64	*598,660*	*X*	*30 beds/100,000= 179.6 beds*
Age 65+	*233,652*	*X*	*30 beds/100,000 = 70.1 beds*
			Total=314.8 beds

3. For child inpatient under age 13, and if adolescent program the age group of 13-17 should be used.

The applicant is planning to provide both child and adolescent inpatient psychiatric units. The bed need was calculated based on the age group 0-17 years.

It appears that this criterion has been met.

4. These estimates for total need should be adjusted by the existent staffed beds operating in the area as counted by the Department of Health in the Joint Annual Report.

Service Area	Population 2016			Gross Need Pop. X (30 beds/100,000)			Current Beds			Net Need		
	C & A 0-17	Adult 18-64	65+	C & A 0-17	Adult 18-64	65+	C & A 0-17	Adult 18-64	65+	C & A 0-17	Adults 18-64	65+
18 County Service Area (TN)	215,353	596,632	203,262	65	179	61	108	259	28	(43) Surplus	(80) Surplus	+33 (need)
	Population 2020			Gross Need Pop. X (30 beds/100,000)			Current Beds			Net Need		
18 County Service Area (TN)	217,133	598,660	233,652	65.13	179.60	70.09	108	259	28	(42.87) Surplus	(79.40) Surplus	+42.09 (need)
	% change in population 2016-2020			Change in Gross Need 2016-2020						Change in Net Need 2016-2020		
	+0.83%	+0.34%	+13.01%	+0.13	+0.60	+9.09				+0.13	+0.60	+9.09

Source: HSDA Staff Calculations using 2015 Revised UT Center for Business and Economic Research Population Projection Data Files.

Bed Formula for Children/Adolescent

Subtracting the 108 existing beds (HSDA includes licensed beds rather than staffed beds in calculating existing beds) from the 65.13 child/adolescent psychiatric bed need results for 2020, results in a net bed surplus of 42.9 beds. The applicant is requesting 18 child/adolescent beds.

It appears that this criterion has not been met.

Bed Formula for Adults 18-64

When considering the only adult beds for ages 18-64, there is a projected need in 2020 of 179.60 beds. Subtracting 179.60 beds from the 259 existing adult psychiatric bed total (HSDA includes licensed beds rather than staffed beds in calculating existing beds) results in a net bed surplus of 79.40 adult beds for ages 18-64. The applicant is requesting 24 adult beds.

When considering only the age 18-64 adult population in the bed need formula, it appears that this criterion has not been met.

Bed Formula for Adults 65 and over

Applying this formula to only the age 65+ population results in a projected net bed need in 2020 of 42.09 beds (70.09 projected bed need minus current beds (HSDA includes licensed beds rather than staffed beds in calculating existing beds) of 28). The applicant is requesting 12 geriatric beds.

When considering only the age 65+ population in the bed need formula, it appears that this criterion has been met.

Bed Formula for All Ages

Applying this formula to the total population in 2020 the result is a projected net bed surplus of approximately 80 (315 projected bed need minus current beds (HSDA includes licensed beds rather than staffed beds in calculating existing beds) of 395). The applicant is requesting an 88 bed mental health hospital.

When considering the total population in the bed need formula, it appears that this criterion has not been met.

Note to Agency Members: There are some minor differences between the HSDA Staff Summary and the TDMHSAS report pertaining to calculated bed need. The TDMHSAS report considers existing staffed beds (380) as delineated in the criterion above. The HSDA staff summary used licensed beds (395) in determining existing beds. HSDA staff feels that licensed beds are a better measure of bed inventory.

The TDMHSAS report included a bed need calculation using Tennessee's 30 bed/100,000 population formula for the applicant's declared out-of-state service area which includes 9 counties in Georgia, 2 counties in Alabama and 1 county in North Carolina. The TDMHSAS report projected a Year 2020 net bed need of 142 inpatient psychiatric beds in the out-of-state counties.

B. Service Area

1. The geographic service area should be reasonable and based on an optimal balance between population density and service proximity or the Community Service Agency.

The service area is based upon the applicant's current patient origin. It appears that this criterion has been met.

2. The relationship of the socio-demographics of the service area, and the projected population to receive services, should be considered. The proposal's sensitivity to and responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, and those needing services involuntarily.

Those requiring voluntary and involuntary inpatient psychiatric services will receive services closer to their homes which will provide greater patient accessibility, support system, and family participation.

TennCare/Medicaid patients will be admitted, as will as charity patients.

Note to Agency members: The TDMHSAS report states that Parkridge Valley does accept some involuntary admissions but only those with insurance. Erlanger Behavioral Health and Moccasin Bend Mental Health Institute would be the only hospitals in the area that accept involuntary admissions of uninsured persons.

It appears that this criterion has been met.

C. Relationship to Existing Applicable Plans

1. The proposal's relationship to policy as formulated in state, city, county, and/or regional plans and other documents should be a significant consideration.

There are no identified state, city, county, or regional planning documents.

This criterion does not apply to this application.

2. The proposal's relationship to underserved geographic areas and underserved population groups as identified in state, city, county and/or regional plans and other documents should be a significant consideration.

According to the U.S. Department of Health and Human Resources, numerous counties (including Hamilton County) in the defined service are designated as medically underserved areas (MUAs).

It appears that this criterion has been met.

3. The impact of the proposal on similar services supported by state appropriations should be assessed and considered.

Moccasin Bend Mental Health Institute (MBMHI) located in Chattanooga (Hamilton County), TN serves service area residents and is supported by state appropriation. The applicant impact upon the Regional Mental Health Institutes will be minimal since MBMHI primarily serves long-term patients who are severely mentally ill and Erlanger Behavioral Health will focus on short term stays.

It appears that this criterion has been met.

4. The proposal's relationship to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, should be assessed and considered.

The applicant plans to accept both voluntary and involuntary admissions.

It appears that this criterion has been met.

5. The degree of projected financial participation in the Medicare and TennCare programs should be considered.

The applicant projects a payor mix of 25.7% TennCare and 32.6% Medicare.

It appears that this criterion has been met.

D. Relationship to Existing Similar Services in the Area

1. The area's trends in occupancy and utilization of similar services should be considered.

There are 7 inpatient psychiatric facilities representing 395 beds in the 18 county Tennessee service area. The licensed occupancy of the 395 beds was 63.9% in 2012, 74.0% in 2013, and 74.5% in 2014. The applicant provided utilization tables on page 41-R in the original application.

It appears that this criterion has been met.

2. Accessibility to specific special need groups should be an important factor.

The applicant will provide adequate culturally and linguistically appropriate mental health care to racial and ethnic populations.

It appears that this criterion has been met.

E. Feasibility

The ability of the applicant to meet Tennessee Department of Mental Health and Substance Abuse Services (DMHSAS) licensure requirements (related to personnel and staffing for psychiatric inpatient facilities) should be considered.

The applicant confirmed it will meet all licensure requirements of the Tennessee Department of Mental Health and Substance Abuse Services.

It appears the application meets this criterion.

STAFF SUMMARY

Note to Agency members: This staff summary is a synopsis of the original application and supplemental responses submitted by the applicant. Any HSDA Staff comments will be presented as a "Note to Agency members" in bold italic.

Erlanger Behavioral Health, LLC, is a joint venture between Erlanger Health System and Acadia Healthcare. Erlanger Behavioral Health, LLC seeks to construct an 88 licensed inpatient bed freestanding psychiatric facility. If approved, Erlanger North Hospital will transfer its current twelve licensed geriatric beds to Erlanger Behavioral Health, LLC. The remaining 76 psychiatric inpatient beds will represent new inpatient psychiatric beds added to the

proposed 18 county service area. The distance from Erlanger Medical Center to Erlanger Behavioral Health is 1.1 miles, and from Erlanger North Hospital is 8.4 miles.

Erlanger Health System is currently in discussion with the University of Tennessee-College of Medicine about designating the new hospital an academic medical center where a psychiatric graduate medical education residency program would be established.

The projected completion date of the proposed project is June 2018.

Need

The applicant provides the following need justification in the application:

- Based on the current psychiatric bed need criteria, the defined service area is in need of an additional 42.1 geriatric inpatient beds.
- In the period from October 1, 2014 to September 30, 2015, Erlanger Health System had a total of 34,853 inpatient discharges, and of that there were 11,561 discharges with a mental health condition, 6,468 of those patients were admitted as inpatients through the Emergency Department.
- There is a critical need for additional inpatient psychiatric beds from the community and institutional need perspective.

Ownership

The ownership structure for the applicant is as follows:

- The applicant, Erlanger Behavioral Health, LLC, is 51% majority owned by Erlanger Health System, and 49% owned by Acadia Healthcare.
- Chattanooga-Hamilton County Hospital Authority d/b/a the Erlanger Health System owns Erlanger Medical Center (EMC). EMC currently has 788 licensed beds in Hamilton County.
- The components of Erlanger Health System include: Erlanger Medical Center (688 licensed beds) which includes the Children's Hospital at Erlanger (121 licensed beds) on the main campus; Erlanger East Hospital (43 licensed beds) on the East Campus; Erlanger North Hospital (57 licensed beds) on the North Campus.
- In addition to the hospitals in Hamilton County, Erlanger Health System includes separately licensed Erlanger Bledsoe (25 licensed beds) located in Bledsoe County.
- Acadia operates 585 behavioral health facilities with approximately 17,100 beds in 39 states, the United Kingdom and Puerto Rico.
- Acadia operates an outpatient methadone clinic in Chattanooga (Hamilton County).

Facility Information

- The 69,000 SF proposed 2 story building will include 50,900 SF on the first floor and 18,100 SF on the second floor.
- The facility will include an in-house pharmacy, gymnasium, consultation rooms, seclusion and/or quiet rooms, and common rooms for groups, activities, dining, leisure, and visitation.
- Please refer to the floor plans in attachment B-IV for additional information.
- The proposed facility will be located on 6.02 acres and will contain approximately 129 parking spaces of which 6 will accommodate those who are handicapped.
- A letter dated March 14, 2016 from Stengill-Hill Architecture, states the construction project will be designed and built to all applicable State and Federal Regulations.

Service Area Demographics

Tennessee Service Area

Erlanger Behavioral Health, LLC's declared Tennessee portion of the service area, which includes, primary service area counties (Hamilton), secondary service area counties (Bledsoe, Bradley, Grundy, Marion, McMinn, Meigs, Polk, Rhea, and Sequatchie) and tertiary service area counties (Coffee, Cumberland, Franklin, Loudon, Monroe, Roane, Van Buren, and Warren).

- The total population of the Tennessee portion of the service area is estimated at 1,015,247 residents in calendar year (CY) 2016 increasing by approximately 3.4% to 1,049,445 residents in CY 2020.
- The total 65+ age population is estimated at 203,262 residents in CY 2016 increasing approximately 15.0% to 233,652 residents in 2020.
- The total population of the state of Tennessee is expected to grow 4.3% during the same timeframe.
- The 65+ age population in the state of Tennessee overall is expected to increase 12.0% during the same timeframe.
- The latest 2016 percentage of the Tennessee portion of the service area population enrolled in the TennCare program is approximately 21.8%, as compared to the statewide enrollment proportion of 19.6%.

Source: The University of Tennessee Center for Business and Economic Research Population Projection Data Files, Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics.

Out-of-State Service Area

- The applicant's declared out-of-state secondary service area consists of 3 counties (Catoosa, Dade, and Walker) in Georgia.
- The applicant's declared tertiary service area includes the following: 2 Alabama counties (DeKalb and Jackson); 6 Georgia counties (Chattooga, Fannin, Gilmer, Gordon, Murray, and Whitfield); and Cherokee County in North Carolina.

Service Area Historical Utilization

The reported regional inpatient psychiatric inpatient Joint Annual Report utilization data for the latest three available years is contained in the table below.

2012-2014 Service Area Acute Care Hospitals Inpatient Psychiatric Beds

Facility	County	2014 Licensed Beds	Patient Days			Licensed Occupancy			% Change 2012-2014
			2012	2013	2014	2012	2013	2014	
Parkridge Valley Hospital	Hamilton	172	39,153	44,968	42,623	62.4%	71.6%	67.9%	+8.9%
Erlanger North Hospital	Hamilton	12	3,746	3,761	3,628	85.5%	85.9%	82.8%	-3.2%
Parkridge Medical Ctr.	Hamilton	0	*2,793 11 lic beds	N/A	N/A	69.6%	N/A	N/A	N/A
Parkridge West Hospital	Marion	20	5,278	5,055	4,930	72.3%	69.3%	67.5%	-6.6%
Skyridge Medical Center	Bradley	29	1,362	1,038	2,203	12.9%	9.8%	20.8%	+61.8%
Southern TN Med. Ctr.	Franklin	12	4,421	3,916	4,170	100.9%	89.4%	95.2%	-5.7%
Area total w/o MBMHI		**245**	**56,753**	**58,738**	**57,554**	**61%**	**59.9%**	**61.9%**	**+1.4%**
Moccasin Bend	Hamilton	150	37,970	47,908	49,875	69.1%	87.5%	87.5%	+31.5%
Total		**395**	**94,723**	**106,646**	**107,429**	**63.9%**	**74%**	**74.5%**	**+13.4%**

Source: *Joint Annual Report of Hospitals 2012-2014*, Division of Health Statistics, Tennessee Department of Health

**Parkridge Medical Center moved its Adult and Geriatric beds to a new campus in 2014.*

- The overall utilization of psychiatric inpatient acute facilities (minus MTMHI) in the primary service area increased 1.4% from 56,753 patient days in 2012 to 57,554 days in 2014.
- The overall utilization of all psychiatric inpatient acute facilities (MBMHI included) in the service area increased 13.4% from 94,723 patient days in 2012 to 107,429 days in 2014.
- In 2015 the licensed occupancy of psychiatric inpatient facilities ranged from 20.8% at Skyridge Medical Center to 95.2% at Southern Tennessee Medical Center.

Applicant Historical and Projected Utilization

Historical Utilization

As mentioned earlier, the applicant is requesting approval to transfer 12 licensed geriatric psychiatric beds currently at Erlanger North Hospital to the new proposed Erlanger Behavioral Health campus. The following chart represents the historical utilization of Erlanger North Hospital's current 12 beds inpatient geriatric unit.

Erlanger North Hospital-Historical Geriatric Utilization-12 beds

	Licensed Beds	Patient days			Occupancy			% Change
		2012	2013	2014	2012	2013	2014	
Erlanger North Hospital (Present Location)	12	3,746	3,761	3,628	85.5%	85.9%	82.8%	-3.2%

Source: CN1603-012

- The occupancy of the current Erlanger North Hospital geriatric unit averaged 84.8% during the reporting period 2012 to 2014.
- There was a 3.2% decline in patient days from 3,746 in 2012 to 3,628 in 2014.

Applicant Projected Utilization

The applicant's projected hospital overall inpatient utilization is presented in the following table.

Year	Beds	Patient Days	ADC	% Occupancy
Year 1 (2018)	88	8,798	24.1	27.4%
Year 2 (2019)	88	17,481	47.9	54.4%

Source: CN1603-012

The break-out of the proposed average daily census (ADC) by inpatient behavioral unit for Year One and Year Two is noted in the following table:

	Year One-ADC	Year Two-ADC

Adult Psychiatric Unit (24 beds)	4.0	10.0
Gero Psychiatric Unit (24 Beds)	12.0	18.0
Child and adolescent beds (18 beds)	4.0	10.0
Chemical Dependency Unit (22 beds)	4.1	9.9
Total	**24.1**	**47.9**

Source: CN1603-012

Project Cost

Major costs are:

- Construction Cost plus Contingency- $19,720,000, or 78.5% of cost.
- Preparation of Site- $1,800,000, or 7.2% of cost.
- Architectural and Engineering Fees: $1,632,600, or 6.5% of the total cost.
- For other details on Project Cost, see the Project Cost in the original application.
- The new construction cost is $271.30 per square foot (/SF). As reflected in the table below, the new construction cost is between the first quartile cost of $244.85/SF and median cost of $308.43/SF of statewide hospital projects from 2013 to 2015.

Statewide Hospital Construction Cost per Square Foot
2013-2015

	Renovated Construction	New Construction	Total Construction
1st Quartile	$160.66/sq. ft.	$244.85/sq. ft.	$196.62/sq. ft.
Median	$223.91/sq. ft.	$308.43/sq. ft.	$249.67/sq. ft.
3rd Quartile	$297.82/sq. ft.	$374.32/sq. ft.	$330.50/sq. ft.

Source: HSDA Applicant's Toolbox

Financing

An April 8, 2016 letter from the Bank of America confirms the availability of approximately $206,000,000 of secured revolving credit at a rate of approximately 3.69% maturing in February 2019.

Acadia Healthcare Company, Inc.'s consolidated audited financial statements for the period ending December 31, 2015 indicates $11,215,000 in cash, total current

assets of $294,736,000, total current liabilities of $290,203,000, and a current ratio of 1.02:1.

Note to Agency members: Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

Historical Data Chart

- As a newly formed limited liability company, the applicant LLC has no prior record of inpatient behavioral health operations.

Projected Data Chart

The applicant projects $12,001,800.00 in total gross revenue on 8,798 days during the first year of operation and $26,867,331 on 17,481 days in Year Two (approximately $1,537 per day). The Projected Data Chart reflects the following:

- Net operating income less capital expenditures for the applicant will equal ($1,211,921) in Year One increasing to $114,438 in Year Two.
- Net operating revenue after contractual adjustments is expected to reach $10,921,810 or approximately 40.7% of total gross revenue in Year Two.

Charges

In Year One of the proposed project, the average charges are as follows:

- The proposed average gross charge is $1,364/day in 2018.
- The average deduction is $833/day, producing an average net charge of $531/day.

Medicare/TennCare Payor Mix

- The applicant indicates it has plans to contract with all TennCare MCOs available to its service area population: United HealthCare Community Plan, Blue Care/TennCare Select, and AmeriGroup.

Applicant's Payor Mix, Year 1

Payor Source	Gross Revenue Year 1	as a % of Gross Revenue Year 1
Medicare	$3,917,249	32.6%
TennCare	$3,086,317	25.7%
Commercial	$3,561,135	29.7%
Self Pay	$1,068,341	8.9%

Other	$368,758	3.1%
Total	**$12,001,800**	**100%**

Source: CN1603-012

Staffing

The applicant's proposed Year 2 direct patient care staffing includes the following:

Position	Total
MD	1.6
Director of Nursing	1.0
Nurses	11.3
Nurse Assistant	31.9
Social Worker	12.0
Mental Health Tech	17.0
Total	**74.80**

Source: CN1603-012, Additional Information, 5/18/2016 requesting by the TDMHDD.

Licensure/Accreditation

Erlanger Behavioral Health, LLC plans to be licensed by the Tennessee Department of Mental Health and Substance Abuse Services and accredited by The Joint Commission.

The applicant has submitted the required information on corporate documentation and title and deeds. Staff will have a copy of these documents available for member reference at the meeting. Copies are also available for review at the Health Services and Development Agency's office.

Should the Agency vote to approve this project, the CON would expire in three years.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:

There are no other Letters of Intent, denied, pending applications, or outstanding Certificates of Need for this applicant.

Erlanger Health System has financial interests in this project and the following:

Outstanding Certificates of Need

Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger East, CN 0405-047AE, has an outstanding Certificate of Need that, following three modifications for extension of the time, will expire on December 1, 2016. The CON was approved at the October 27, 2004 Agency meeting for the construction of a new four (4) story patient tower and other ancillary space: transfer of seventy-nine (79) beds from the main Erlanger campus to the east campus: initiation of cardiac catheterization and acquisition of a magnetic resonance imaging (MRI) scanner. This project will decrease the main campus beds from 703 to 624 licensed beds. The 79 licensed beds will be transferred to the Erlanger East Hospital satellite campus resulting in an increase of 28 to 107 licensed beds at that location. The estimated project cost is **$68,725,321.00.** *Project Status Update: The project expiration date was extended to December 1, 2016 at the September 24, 2014 Agency meeting (the project's 4th approved extension request). Per an email dated 5/6/16 from a representative of the applicant, the project, which includes the transfer of 79 beds from Erlanger Medical Center, is well on its way to completion. Target occupancy/completion is 12/1/2016 or before. The project has been opened in phases including a new emergency department, ancillary services, outpatient services expanded nursery and imaging. The bed tower is now under construction. The project is expected to be completed on schedule at or below the CON authorized cost.*

Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Medical Center, CN1207-034AE, has an outstanding Certificate of Need that will expire on November 1, 2017 (as modified from original expiration date of December 1, 2015). The CON was approved at the October 24, 2012 Agency meeting for the renovation, upgrade and modernization of adult operating rooms, including the addition of four (4) new operating rooms. No other health care services will be initiated or discontinued. The estimated project cost is **$21,725,467.00.** *Project Status Update: An email dated 5/16/16 from a representative of the applicant noted approximately 75% of the project has been completed. The project is expected to be completed on schedule and within the authorized budget.*

Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Medical Center, CN1412-048A, has an outstanding Certificate of Need that will expire on May 1, 2018. The project was approved at the March 25, 2015 Agency meeting for the acquisition of a linear accelerator and the initiation of services at Erlanger East Hospital at 1755 Gunbarrel Road, Chattanooga, TN a satellite hospital operating under the license of Erlanger Medical Center, 975 East 3rd Street, Chattanooga (Hamilton County), Tennessee. The new linear accelerator at Erlanger East Hospital will replace a linear accelerator at Erlanger Medical Center reducing the number of linear accelerators at Erlanger Medical Center

from two to one. The estimated project cost is **$10,532,562.00.** *Project Status Update: An email dated 5/16/16 from a representative of the applicant noted that this expansion project includes the relocation and replacement of a linear accelerator from Erlanger Medical Center to Erlanger East Hospital and the development of a full service cancer center. The cancer center will be housed in newly constructed building, now in design, that will also house space for support services. The project is expected to be completed on or before May 1, 2018 at or below CON authorized cost.*

Chattanooga-Hamilton County Hospital dba Erlanger East Hospital, CN1502-005A, has an outstanding Certificate of Need that expires on July 1, 2018. The project was approved at the May 27, 2015 Agency meeting to modernize the CON originally issued in 2004 (CN0405-047AE) which was approved for diagnostic services. The project involves the upgrade of the unimplemented diagnostic cardiac catheterization lab to also perform interventional cardiac procedures. The estimated project cost is **$303,000**. *Status Update: An Annual Progress Report dated 6/6/2016 indicates the project is on schedule and on budget.*

Children's Hospital at Erlanger and Erlanger East Hospital, CN1601-002A, has an outstanding Certificate of Need that will expire on July 1, 2019. The project was approved at the May 25, 2016 Agency meeting for the initiation of a 10 bed level 3 neonatal intensive care service, through the transfer of 10 medical/surgical beds from Erlanger Medical Center to Erlanger East Hospital located at 1755 Gunbarrel Road in Chattanooga (Hamilton County), TN 3416 and reclassification of the 10 beds as Level III Neonatal Intensive Care beds. These beds will be built in 8,805 SF of new construction resulting in a project cost in excess of $5M. The licensed bed complement of Erlanger East Hospital will increase from 113 to 123 total beds. The estimated project cost is **$7,021,555.** *Project Status: This project was recently approved.*

Acadia Healthcare has financial interests in this project and the following:

Pending Projects

TrustPoint Hospital, LLC, CN1606-024, has an application that will be heard at the October 26, 2016 Agency meeting for the addition of a newly constructed 119,500 SF building to be connected to the existing hospital located at 1009 North Thompson Lane, Murfreesboro (Rutherford County), TN. If approved, the project will add 88 psychiatric beds to the existing 129 bed hospital resulting in a total of 217 licensed beds. The applicant intends to increase the following inpatient bed types: Adult Psychiatric beds from 59 to 111 beds; Physical Rehabilitation beds will increase from 16 beds to 24 beds; Child Psychiatric beds

will increase from 0 beds to 14 beds; Adolescent Psychiatric will increase from 0 to 14 beds. In addition to the 88 CON reviewable hospital beds, there will be 32 residential care beds constructed in the new building, half (16 beds for adolescents and half (16) for children. The 32 residential care beds are not subject to Certificate of Need review. The project Cost is **$57,320,105.**

Outstanding Certificates of Need

Crestwyn Behavioral Health, CN1310-040A, has an outstanding Certificate of Need that will expire on June 1, 2017. The project was approved at the April 23, 2014 Agency meeting for the establishment of a 60 bed mental health hospital. The beds are designated in the following manner: 15 beds dedicated to psychiatric care for adolescents: 30 for adults of all ages; and 15 for adult chemical dependency care. Delta Medical Center will delicense 60 beds. The estimated project cost is $26,875,862. *Project Status: A representative of the applicant sent an Annual Progress Report dated March 28, 2016 that indicated the project completion date is March 31, 2016 with the issuance of a license scheduled to follow. A final project report is pending.*

TrustPoint Hospital, CN1502-006A, has an outstanding Certificate of Need that will expire on July 1, 2018. The project was approved at the May 25, 2015 Agency meeting for the net increase of 33 inpatient beds as follows: Adult Psychiatric Beds will increase from 31 beds to 59; Geriatric Psychiatric will increase from 28 beds to 36; Medical Detoxification beds will increase from 10 to 18 beds, Physical Rehabilitation Beds will decrease from 27 beds to 16 beds; with total beds increasing from 96 to 129 beds. The estimated project cost is $935,000.00. *Project Status: A representative of the applicant provided a project update on July 25, 2016 which stated the following: "On May 1, 2016, TrustPoint Hospital was purchased by Acadia Healthcare Company, Inc. As part of that purchase, the leadership examined the current and long term needs of the hospital and community. A decision was made to file a new CON application to add additional acute beds beyond those provided in the current CON. The beds remaining in the current CON will be implemented with the construction resulting from the new CON (CN1502-006). The hospital anticipates approval of its new CON application in the September/October cycle, with construction to commence immediately thereafter".*

CERTIFICATE OF NEED INFORMATION FOR OTHER FACILITIES IN THE SERVICE AREA:

There are no other Letters of Intent, denied, or pending applications for other health care organizations in the service area proposing this type of service.

Outstanding Certificates of Need

Starr Regional Medical Center--Etowah, CN1404-009A, has an outstanding Certificate of Need that will expire on September 1, 2017. The project was approved at the July 23, 2014 Agency meeting for the expansion of the hospital's existing 10 bed geri-psychiatric unit to 14 beds. The expansion of the geriatric psychiatric unit will be accomplished without increasing the total bed complement of the Etowah satellite (72) by redistributing 4 acute care beds (medical-surgical) to the geriatric psychiatric classification. This reclassification will not impact the total beds physically located at the main campus in Athens (118) or the total licensed beds for both sites (190). The estimated project cost is $1,282,050.00. *Project Status: A representative of the applicant provided a project update on August 1, 2016 which stated the project is completed and a final project report is pending.*

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

PME
(7/20/2016)

LETTER OF INTENT

LETTER OF INTENT
TENNESSEE HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Chattanooga Times Free Press, which is a newspaper of general circulation in Hamilton County, Tennessee, on or before March 10, 2016, for one day.

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et. seq.*, and the Rules of the Health Services & Development Agency, that Erlanger Behavioral Health, LLC, with an ownership type of for profit, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to construct a new psychiatric hospital with a total complement of eighty-eight (88) inpatient beds, to include services for inpatients, outpatients and substance abuse. Further, we are requesting approval to transfer twelve (12) licensed Geriatric – Psychiatric beds currently at Erlanger North Hospital to the new Erlanger Behavioral Health campus. This will create a net addition of seventy-six (76) new inpatient psychiatric beds. If approved, the number of hospital beds at Erlanger North Hospital will decrease from fifty seven (57) beds to forty-five (45) beds upon completion of the project. No other health care services will be initiated or discontinued.

The facility and equipment will be located at Erlanger Behavioral Health, at a site located at the intersection of North Holtzclaw Avenue & Citico Avenue, Chattanooga, Hamilton County, Tennessee, 37404. The total project cost is estimated to be $ 25,112,600.00.

The anticipated date of filing the application is March 15, 2016.

The contact person for this project is Joseph M. Winick, Sr. Vice President, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee, 37403, and by phone at (423) 778-7274.

Joseph M. Winick	March 8, 2016	Joseph.Winick@erlanger.org
	Date:	E-Mail:

The Letter Of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter Of Intent must contain the following statement pursuant to T.C.A. §68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

ORIGINAL APPLICATION

CERTIFICATE OF NEED APPLICATION

Erlanger Behavioral Health, LLC

Application To Initiate Psychiatric Services At The
Intersection Of North Holtzclaw Avenue And Citico Avenue,
In Chattanooga, Tennessee, With Establishment
Of An Eighty-Eight (88) Bed Inpatient Hospital
By The Addition Of Seventy-Six (76) Psychiatric Beds
And The Transfer Of Twelve (12) Geriatric-Psychiatric Beds
From *Erlanger North Hospital*

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

Section A

APPLICANT PROFILE

Section A: APPLICANT PROFILE

Please enter all Section A responses on this form. All questions must be answered. If an item does not apply, please indicate "N/A". ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable item Number on the attachement.***

1. Name of Facility, Agency, or Institution.

Erlanger Behavioral Health, LLC
A Site Located At The Intersection Of
North Holtzclaw Avenue & Citico Avenue
Hamilton County
Chattanooga, TN 37404

2. Contact Person Available For Responses To Questions.

Joseph M. Winick, Sr. Vice President
Planning & Business Development
Erlanger Health System
975 East 3rd Street
Chattanooga, TN 37403
(423) 778-8088
(423) 778-5776 -- FAX
Joseph.Winick@erlanger.org -- E-Mail

3. Owner of the Facility, Agency, or Institution.

Erlanger Behavioral Health, LLC
975 East 3rd Street
Hamilton County
Chattanooga, TN 37403

4. Type of Ownership or Control.

A.	Sole Proprietorship	
B.	Partnership	
C.	Limited Partnership	
D.	Corporation (For Profit)	
E.	Corporation (Not-for-Profit)	
F.	Governmental (State of TN or Political Subdivision)	
G.	Joint Venture	
H.	Limited Liability Company	X

I. Other (Specify) _____

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

-- A copy of the *Articles Of Organization* issued by the Tennessee *Secretary of State* is attached at the end of this CON application.

5. Name of Management / Operating Entity (if applicable).

*** Not Applicable. ****

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. Legal Interest in the Site of the Institution

(*Check One*)

A.	Ownership	_____
B.	Option to Purchase	X
C.	Lease of _____ Years	_____
D.	Option to Lease	_____
E.	Other (Specify)	_____

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. Type of Institution

(*Check as appropriate - more than one response may apply*)

A.	Hospital (Specify) _____	_____
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	_____
C.	ASTC, Single Specialty	_____
D.	Home Health Agency	_____
E.	Hospice	_____
F.	Mental Health Hospital	X
G.	Mental Health Residential Treatment	

	Facility	____
H.	Mental Health Institutional Habilitation Facility (ICF/MR)	____
I.	Nursing Home	____
J.	Outpatient Diagnostic Center	____
K.	Recuperation Center	____
L.	Rehabilitation Facility	____
M.	Residential Hospice	____
N.	Non-Residential Methadone Facility	____
O.	Birthing Center	____
P.	Other Outpatient Facility (Specify) _____	____
Q.	Other (Specify) _____	____

8. Purpose of Review

(Circle Letter(s) as appropriate - more than one response may apply)

A.	New Institution	X
B.	Replacement/Existing Facility	____
C.	Modification/Existing Facility	____
D.	Initiation of Health Care Service As Defined In TCA § 68-11-1607(4) (Specify) Psychiatric Services	X
E.	Discontinuance of OB Services	____
F.	Acquisition of Equipment	____
G.	Change in Beds	X
	[*Please note the type of change by underlining the appropriate response:* Increase, Decrease, Designation, Distribution, Conversion, Relocation]	
H.	Change of Location	____
I.	Other (Specify) _____	____

9. Bed Complement Data

Please indicate current and proposed distribution and certification of facility beds.

		Licensed Beds	*(*) CON Beds*	*Staffed Beds*	*Beds Proposed*	*TOTAL Beds at Completion*
A.	Medical					
B.	Surgical					
C.	Long-Term Care Hospital					
D.	Obstetrical					
E.	ICU / CCU					
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric				24	24
I.	Geriatric Psychiatric				24	24
J.	Child / Adolescent Psychiatric				18	18
K.	Rehabilitation					
L.	Nursing Facility (Non – Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid / Medicare)					
P.	ICF / MR					
Q.	Adult Chemical Dependency				22	22
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL				88	88

(*) CON Beds approved but not yet in service.

Notes
(1) *Erlanger Behavioral Health* seeks approval for the addition of 76 psychiatric beds with this CON.
(2) *Erlanger North Hospital* currently operates twelve (12) Geriatric-Psychiatric beds and will transfer these beds to *Erlanger Behavioral Health*.

10. **Medicare Provider Number** Application will be made prior to opening of the facility.

Certification Type _____

11. **Medicaid Provider Number** Application will be made prior to opening of the facility.

Certification Type _____

12. If this is a new facility, will certification be sought for Medicare and / or Medicaid ?

Yes X No _____

13. Identify all TennCare Managed Care Organizations / Behavioral Health Organizations (MCO's/BHO's) operating in the proposed service area.* Will this project involve the treatment of TennCare participants ?** *Yes* **If the response to this item is yes, please identify all MCO's/BHO's with which the applicant has contracted *or plans to contract.

Discuss any out-of-network relationships in place with MCO's/BHO's in the area.

Response

It is anticipated that *Erlanger Behavioral Health* will have patient service agreements with substantially the same Managed Care Organizations ("MCO's") as *Erlanger Health System*, as well as other Behavioral Health Organizations ("BHO's"). These agreements will be developed separately from the MCO contracts which are currently in place with *Erlanger Health System*.

Erlanger Health System is well positioned to develop agreements with MCO's and BHO's in the service area. With the initiation of the *Health Care Exchanges* under the *Affordable Care Act* on January 1, 2014; *Blue Network E* enrolled over 10,000 uninsured people and *Erlanger* is the only provider in this network. Further, an additional 7,000 people were enrolled in *Blue Network S* and *Erlanger* is one of only two providers in this network. *Erlanger* is the low cost and safety net provider in the regional service area and participates in narrow networks to facilitate needed care for those who would otherwise not be able to receive it.

Erlanger Health system currently has contracts with the following MCO's.

A. TennCare Managed Care Organizations

-- BlueCare
-- TennCare *Select*
-- AmeriGroup Community Care
-- United Healthcare Community Plan

B. Georgia Medicaid Managed Care Organizations

-- AmeriGroup Community Care
-- Peach State Health Plan
-- WellCare Of Georgia

C. Commercial Managed Care Organizations

-- Blue Cross / Blue Shield of Tennessee
  - Blue Network P
  - Blue Network S
  - Blue Network E
  - Blue CoverTN
  - Cover Kids
  - AccessTN
  - Blue Advantage
-- Blue Cross of Georgia (HMO & Indemnity)
-- Baptist Health Plan
-- CIGNA Healthcare of Tennessee, Inc.
  (includes LocalPlus)
-- CIGNA Lifesource (Transplant Network)
-- UNITED Healthcare of Tennessee, Inc.
  (Commercial & Medicare Advantage)
-- Aetna Health
-- Health Value Management D/B/A Choice Care Network (Commercial & Medicare Advantage)
-- HUMANA
  (Choicecare Network, HMO, PPO, POS & Medicare Advantage)
-- HUMANA Military
-- Cigna-HealthSpring
  (Commercial & Medicare Advantage)
-- WellCare Medicare
-- Olympus Managed Health Care, Inc.
-- TriWest (VAPC3)

D. Alliances

-- Health One Alliance

E. Networks

-- Multi-Plan (includes Beech Street & PHCS)
-- MCS Patient Centered Healthcare
-- National Provider Network
-- NovaNet (group health)
-- USA Managed Care Corp.
-- MedCost
-- Alliant Health Plan
-- Crescent Preferred Provider Organization
-- Evolutions Healthcare System
-- Prime Health Resources
-- Three Rivers Provider Network
-- Galaxy Health Network
-- First Health Network
-- Integrated Health Plan
-- Logicomp Business Solutions, Inc.
-- HealthSCOPE Benefits, Inc.
-- HealthCHOICE (Oklahoma State & Education Employees Group Insurance Board).

F. Other

-- Alexian Brothers Community Services

Section B

PROJECT DESCRIPTION

Section B: PROJECT DESCRIPTION

Please answer all questions on 8 ½" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Response

Erlanger Behavioral Health, will be the region's safety net provider for adults and children. *Erlanger Behavioral Health* seeks approval to construct and initiate inpatient psychiatric services in a new, state of the art, psychiatric hospital. This project represents *Erlanger Health Systems'* effort to enhance its system of care to meet the needs of the vulnerable population's in the four (4) state geography of the defined service area.

Disparity in mental health status and mental health care are critical in determining the greatest need. Specifically, "Blacks, Latino's and Asian Americans are over represented in populations that are particularly at risk for mental health disorders. Additionally, minority individuals may experience symptoms that are undiagnosed, under-diagnosed, or mis-diagnosed for cultural, linguistic, or historical reasons. The lack of attention to the mental and behavioral health needs of racial and ethnic minorities and the inadequate provision of culturally and linguistically appropriate mental health care in racial and ethnic minority communities demonstrates a clear need … to close the gap in care."[1] It should also be noted that in Tennessee, in 2015 the number of poor mental health days

1 *Health Care Reform – Disparities In Mental Health Status & Mental Health Care*, American Psychological Association website … http://www.apa.org/about/gr/issues/health-care/disparities.aspx.

index ranked at 4.8, the worst of every health index measure.

Erlanger Behavioral Health will serve adult (24 beds), geriatric (24 beds), and children / adolescent (18 beds) psychiatric patients, and will also provide adult chemical dependency services (22 beds). Services will include acute inpatient care, partial hospitalization and outpatient care. Further, service will also be provided with a crisis assessment and intake center for patients on an emergency basis, as needed. Behavioral medicine will also be provided to those in need who are affected by various medical conditions.

Proposed Services & Equipment

Erlanger Behavioral Health seeks approval to construct a new state of the art, acute care psychiatric hospital, as well as initiate psychiatric services.

Ownership Structure

Erlanger Behavioral Health is majority owned by *Erlanger Health System*. With 51%, and *Acadia Healthcare* has a minority ownership of 49%.

Acadia Healthcare is the largest provider of behavioral healthcare services. *Acadia* operates a network of 585 behavioral healthcare facilities with approximately 17,100 beds in 39 states, the United Kingdom and Puerto Rico. *Acadia* provides behavioral health and addiction services to its patients in a variety of settings, including inpatient psychiatric hospitals, residential treatment centers, outpatient clinics and therapeutic school-based programs.

Acadia already operates an outpatient methadone treatment clinic in Chattanooga.

Service Area

The service area for this project is defined as Hamilton County, Tennessee, and the counties that surround Hamilton County in Tennessee, Georgia, Alabama and North Carolina. The service area consists of a total of thirty (30) contiguous counties in the four (4) state geography, which is the same service area currently served by *Erlanger Medical Center*. A complete list of the counties which comprise the service area is attached to this CON application.

Need

The need for this project is clearly demonstrated by a broad based analysis of the service area. In short, the defined service area is in need of an additional 219 inpatient psychiatric beds, based on the current Psychiatric bed need criteria.

Further, in the twelve (12) month period from Oct. 1, 2014 – Sep. 30, 2015, EHS had a total of 34,853 inpatient discharges, and of that there were 11,561 discharges with a mental health condition that needed to be treated. Of the 11,561 inpatient discharges with a mental condition, 6,468 of those patients were admitted as inpatients through the Emergency Dept.

In short, there is a critical need for additional inpatient psychiatric beds from both a community need perspective, as well as an institutional need perspective.

Existing Resources

There are currently a total of five (5) provider organizations delivering inpatient psychiatric and substance abuse / chemical dependency services at a total of seven (7) locations within the defined service area, for a total of 252 licensed inpatient beds.

Project Cost

The project cost (per *HSDA* rules) is $ 25,112,600.

Funding

Funding for this project will be provided by *Acadia Healthcare*.

Financial Feasibility

The *Projected Data Chart* shows a positive financial result in year 2 for the project, year 1 includes the start-up cost and twelve (12) months of expense, but only ten (10) months of revenue. The first two (2) months of year 1 are planned for staff training and facility setup, along with other start-up activities.

Staffing

Staffing for the project in year 2 is estimated to be

100.9 FTE's.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and / or renovation to the facility (exclusive of major medical equipment covered by T.C.A. section 68-11-1601 *et seq.*) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $ 5 million) and other facility projects (construction cost in excess of $ 2 million) should complete the Square Footage And Cost Per Square Foot Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Part B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above describe the development of the proposal.

Response

This project calls for the construction of a new eighty-eight (88) bed inpatient hospital providing services for both psychiatric and substance abuse / chemical dependency. *Erlanger Health System* is currently in discussions with it's academic partner, the University of Tennessee – College of Medicine, about making the new hospital an academic medical center like Erlanger where a

graduate medical education and training residency program in Psychiatry would be established.

The bed complement for *Erlanger Behavioral Health* will be twenty-four (24) Adult Psychiatric, twenty-four (24) Geriatric Psychiatric, eighteen (18) Child/Adolescent Psychiatric and twenty-two (22) Adult Chemical Dependency beds. The detail calculations are attached to this CON application.

The new facility will be 69,000 SF with construction cost of $ 18,720,000 and total cost of $ 25,112,600.

B. Identify the number of beds increased, decreased, converted, relocated, designated, and/or distributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

Response

Erlanger Behavioral Health seeks to add seventy-six (76) new psychiatric beds to the service area. *Erlanger North Hospital* will transfer it's current complement of twelve (12) licensed geriatric psychiatric beds to *Erlanger Behavioral Health* with approval and implementation of this CON application. This will be a total of eighty-eight (88) beds for the new hospital.

Erlanger Behavioral Health will have a bed mix of twenty-four (24) Adult Psychiatric, twenty-four (24) Geriatric Psychiatric, eighteen (18) Child/Adolescent Psychiatric and twenty-two (22) Adult Chemical Dependency beds.

In the twelve (12) month period from Oct. 1, 2014 - Sep. 30, 2015, EHS had a total of 34,853 inpatient discharges, and of that there were 11,561 discharges with a mental health condition that needed to be treated. Further, of the 11,561 discharges with a mental condition, 6,468 of those patients were admitted through the Emergency Department. As the 7th largest public health system in the nation, and the healthcare safety net for the region, *Erlanger Health System* is already the defacto provider of behavioral health services for those in need, serving those

who are unable to access care elsewhere. Patients with cancer, cardiac or other complex medical conditions will benefit greatly from the provision of behavioral medicine provided on an outpatient basis. Having a "system of care" available to meet the needs of area residents is paramount to foster access as well as coordinate population health.

Further, disparity in mental health status and mental health care are critical in determining the greatest need. Specifically, "Blacks, Latino's and Asian Americans are over represented in populations that are particularly at risk for mental health disorders. Additionally, minority individuals may experience symptoms that are undiagnosed, under-diagnosed, or mis-diagnosed for cultural, linguistic, or historical reasons. The lack of attention to the mental and behavioral health needs of racial and ethnic minorities and the inadequate provision of culturally and linguistically appropriate mental health care in racial and ethnic minority communities demonstrates a clear need … to close the gap in care.".

The impact of the proposed project on existing services is expected to be negligible in light of the significant need identified, which strongly suggests a tremendous unmet need among those who are most vulnerable, those with TennCare/Medicaid coverage as well the uninsured.

The need for additional behavioral health services to serve the region has been evident at *Erlanger Health System* for some time, and the need for this project is clearly demonstrated by a detailed analysis of the service area. The defined service area is in need of an additional 219 inpatient psychiatric beds, based on the current bed need criteria.

The bed need calculation is derived from the current standard of thirty (30) beds per 100,000 population in the defined service area, less the current bed supply, to arrive at the "net need" for new psychiatric beds in the service area. The 2016 total population is 1,571,392; therefore, the bed requirement is 471 (15.71 x 30), less the current bed supply of 252, yielding a net need for new inpatient psychiatric beds of 219. The need will increase with population growth and other factors in the future.

Square Footage & Cost Per Square Foot Chart

The *Square Footage & Cost Per Square Foot Chart* is attached to this CON application.

C. As the applicant, describe your need to provide the following healthcare services (if applicable to this application):

1.	Adult Psychiatric Services	*** See Below.*
2.	Alcohol and Drug Treatment for Adolescents (exceeding 28 days)	N/A
3.	Birthing Center	N/A
4.	Burn Units	N/A
5.	Cardiac Catheterization Services	N/A
6.	Child/Adolescent Psych. Services	*** See Below.*
7.	Extracorporeal Lithotripsy	N/A
8.	Home Health Services	N/A
9.	Hospice Services	N/A
10.	Residential Hospice	N/A
11.	ICF/MR Services	N/A
12.	Long-Term Care Services	N/A
13.	Magnetic Resonance Imaging (MRI)	N/A
14.	Mental Health Residential Treatment	N/A
15.	Neonatal Intensive Care Unit	N/A
16.	Non-Residential Methadone Treatment Centers	N/A
17.	Open Heart Surgery	N/A
18.	Positron Emission Tomography	N/A
19.	Radiation Therapy/Linear Accelerator	N/A
20.	Rehabilitation Services	N/A
21.	Swing Beds	N/A

Response

Erlanger Behavioral Health seeks to add seventy-six (76) new beds to the service area. *Erlanger North Hospital* will transfer it's current complement of twelve (12) licensed geriatric psychiatric beds to *Erlanger Behavioral Health* with approval and implementation of this CON application. This will be a total of eighty-eight (88) beds in the new hospital.

Erlanger Behavioral Health will have a bed mix of twenty-four (24) Adult Psychiatric, twenty-four (24) Geriatric Psychiatric, eighteen (18) Child/Adolescent

Psychiatric and twenty-two (22) Adult Chemical Dependency beds.

In the twelve (12) month period from Oct. 1, 2014 – Sep. 30, 2015, EHS had a total of 34,853 inpatient discharges, and of that there were 11,561 discharges with a mental health condition that needed to be treated. Further, of the 11,561 discharges with a mental condition, 6,468 of those patients were admitted through the Emergency Department. As the 7th largest public health system in the nation, and the healthcare safety net for the region, *Erlanger Health System* is already the defacto provider of behavioral health services for those in need, serving those who are unable to access care elsewhere. Also, patients with cancer, cardiac or other complex medical conditions will benefit greatly from the provision of behavioral medicine provided on an outpatient basis. Having a "system of care" available to meet the needs of area residents is paramount.

Disparity in mental health status and mental health care are critical in determining the greatest need. Specifically, "Blacks, Latino's and Asian Americans are over represented in populations that are particularly at risk for mental health disorders. Additionally, minority individuals may experience symptoms that are undiagnosed, under-diagnosed, or mis-diagnosed for cultural, linguistic, or historical reasons. The lack of attention to the mental and behavioral health needs of racial and ethnic minorities and the inadequate provision of culturally and linguistically appropriate mental health care in racial and ethnic minority communities demonstrates a clear need … to close the gap in care."

The impact of the proposed project on existing services should be negligible in light of the significant need identified, which strongly suggests a tremendous unmet need among those who are most vulnerable, those with TennCare/Medicaid coverage as well the uninsured.

The need for additional behavioral health services to serve the region has been evident at *Erlanger Health System* for some time, and the need for this project is clearly demonstrated by a detailed analysis of the service area. The defined service area is in need of an additional 219 inpatient psychiatric beds, based on the current bed need criteria.

The bed need calculation is derived from the current standard of thirty (30) beds per 100,000 population in the defined service area, less the current bed supply, to arrive at the "net need" for new beds in the service area. The 2016 total population is 1,571,392; therefore, the bed requirement is 471 (15.71 x 30), less the current bed supply of 252, yielding a net need for new inpatient psychiatric beds of 219. This need will increase with population growth in the future.

D. Describe the need to change location or replace an existing facility.

Response

*** Not Applicable. ***

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $ 2.0 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed site major medical equipment (not replacing existing equipment).

   a. Describe the new equipment, including:

      1. Total Cost (as defined by Agency Rule).
      2. Expected useful life.
      3. List of clinical applications to be provided.
      4. Documentation of FDA approval.

   Response

   *** Not Applicable. ***

   b. Provide current and proposed schedules of operations.

Response

Erlanger Behavioral Health, as an inpatient acute psychiatric hospital will operate 24 hours per day, 365 days per year, along with a crisis assessment and intake center. Outpatient services will be provided Monday - Friday, 8 a.m. - 5 p.m.

2. For mobile major medical equipment:

   a. List all sites that will be served.
   b. Provide current and proposed schedules of operations.
   c. Provide the lease or contract cost.
   d. Provide the fair market value of the equipment.
   e. List the owner for the equipment.

Response

*** Not Applicable. ***

3. Indicate applicant's legal interest in equipment (i.e.-purchase, lease, etc.). In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Response

Applicant currently has legal control of the proposed site through an Option To Purchase, a copy is attached to this CON application.

III. (A) Attach a copy of the plot plan of the site on an 8 ½" x 11" sheet of white paper which **must include**:

1. Size of site (**in acres**).

-- The *Erlanger Behavioral Health* campus is located on approximately 6.0 acres. A copy of the plot plan is attached to this CON application.

2. Location of structure on the site.

-- Please see the location of the facility on the site plan attached to this CON application.

3. Location of the proposed construction.

-- A Site Located At The Intersection Of North Holtzclaw Avenue & Citico Avenue.

4. Names of streets, roads or highways that cross or border the site.

-- Roads that border the site are *N. Holtzclaw Avenue* and *Citico Avenue*.

Please note that the drawings do not need to be drawn to scale. Plot plans are required for <u>all</u> projects.

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

<u>Response</u>

Erlanger Behavioral Health will be easily accessible to patients in Chattanooga, as well as Hamilton and surrounding counties in the service area. The new hospital can be easily accessed via public transportation. Proximal state and interstate highways provide easy access from Tennessee, Georgia, Alabama and North Carolina.

The distance from *Erlanger Medical Center* to *Erlanger Behavioral Health* is 1.1 miles, with a drive time of 2 minutes, is evidenced by the map below. Public transportation is easily accessible to the proposed location. Further, U.S. Highway 27 and U.S. Interstate 24

are major roads in downtown Chattanooga and are within 2.5 miles of the proposed location.

IV. Attach a floor plan drawing which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc., on an 8 ½" x 11" sheet of white paper.

NOTE: ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

Response

A copy of the floor plan is attached to this CON application.

V. For a Home Health Agency or Hospice, identify:

A. Existing service area by County.
B. Proposed service area by County.
C. A parent or primary service provider.
D. Existing branches.
E. Proposed branches.

Response

*** Not applicable. ***

Section C

GENERAL CRITERIA FOR CERTIFICATE OF NEED

Section C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines For Growth), developed pursuant to Tennessee Code Annotated § 68-11-1625.

The following questions are listed according to the three (3) criteria: (1) Need, (2) Economic Feasibility, and (3) Contribution to the Orderly Development of Healthcare. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on 8 ½" x 11" white paper*. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)".

PRINCIPLES OF TENNESSEE STATE HEALTH PLAN

[From 2011 Update, Pages 5-13]

1. ***Healthy Lives***: **The purpose of the State Health Plan is to improve the health of Tennesseans.**

Response

Erlanger Behavioral Health will be a separately licensed affiliate of *Erlanger Health System*, and will share in the safety net mission in southeast Tennessee; though the hospital will also serve northwest Georgia, northeast Alabama and southwest North Carolina due to it's location and the scope and range of services provided. *Erlanger* is often the only health system which low-income people, minorities, and other underserved populations can turn to for treatment.

Disparity in mental health status and mental health care are critical in determining the greatest need. Specifically, "Blacks, Latino's and Asian Americans are over represented in populations that are particularly at risk for mental health disorders. Additionally, minority individuals may experience symptoms that are undiagnosed, under-diagnosed, or mis-diagnosed for cultural, linguistic, or historical reasons. The lack of attention to the mental and behavioral health needs of racial and ethnic minorities and the inadequate provision of culturally and linguistically appropriate mental health care in racial and ethnic minority communities demonstrates a clear need … to close the gap in care."

In order to assure the continued viability of its mission as a safety net hospital, *Erlanger* continually strives to provide services that are the most medically appropriate, least intensive, and provided in the most cost-effective health care setting.

As the safety net provider, a large underserved population depends on *Erlanger* to provide needed services. While it is difficult to predict the outcome of health reform initiatives, many Tennesseans previously without health insurance can be expected to elect services which may have otherwise been postponed. Surveys of the Chattanooga region have shown that some 70% or more of area physicians and surgeons received their training at *Erlanger* via its affiliation with the UT College of Medicine which is located on campus. Based on current residency and fellowship programs, it can be expected that this trend will continue with many physicians opting to remain in Tennessee, at *Erlanger*.

The proposed facility for *Erlanger Behavioral Health* is consistent with the *State Health Plan* because it seeks to ensure patient access to appropriate facilities for Tennesseans in particular. *Erlanger* is the safety net for underserved residents in southeast Tennessee, including the only Children's Hospital within 100 miles of Chattanooga, Tennessee. Providing enhanced access for those in need of care care regardless of the patients' ability to pay has been demonstrated to improve the health status of those served.

The Chattanooga region, particularly Enterprise South Industrial Park, has proven attractive to business

development due to the relatively low cost of labor, cost of living and absence of personal income tax. Also, Chattanooga has been recognized as one of the tenth lowest cost markets from a health care insurance perspective since the roll out of the *Affordable Care Act* and the insurance exchange marketplace.

Volkswagen recently announced that it will invest $600 million in its Chattanooga manufacturing plant, adding a second automobile line to its production facility. In doing so, Volkswagen expects to employ an additional 2,000 employees, with the goal to have the second production line up and running in 2016. *Erlanger* has a primary care site on the Volkswagen campus that serves employees and their families as well as others in the community. Volkswagen also has preferred employer status with *Erlanger*, whereby employees receive a discount when services are provided. With this expansion, parts, paint and other suppliers involved with the manufacturing are also expected to add employees. Volkswagen has released an additional 300 acres of property to house as many as twenty additional supply companies, increasing site employment to 7,500.

Plastic Omnium Auto Exteriors, LLC, a tier one supplier for Volkswagen, also recently announced that it will make a $65 million investment in Chattanooga, creating nearly 200 new positions at opening, with a target of 300 positions within three years. The company has purchased 27 acres in the industrial park where VW is located.

NV Michel Van De Wielke, one of the largest manufacturers of textile machines in the world indicated it would relocate to Chattanooga from Dalton, GA, to be closer to marketplace competitors and challenge rivals for market share. The plant will employ 35. Chattanooga is the birthplace of tufting with a long tradition in the flooring industry and many manufacturers are still in the region. The company will also relocate its headquarters from Charlotte, NC, to Chattanooga.

On the health front, area hospitals have also invested in plant improvements and technology. *Memorial Hospital* recently completed a renovation and expansion project of approximately $ 300 million. *Parkridge Health System*, an affiliate of *HCA Healthcare*, acquired another hospital in the region (*Grandview Hospital*) and recently completed relocation/expansion of its psychiatric facility with

approximately $ 8 million invested. *Tennova Health*, in Bradley County is owned by *Community Health System*, consolidated two facilities and invested approximately $ 45 million in upgrades.

Investment in the region is expected to continue across all industries for the foreseeable future. The Chattanooga Area Chamber of Commerce estimates that it's goal of adding more than 15,000 jobs by the end of 2015, has been met.

2. *Access To Care*: Every citizen should have reasonable access to care.

Response

Erlanger is designated by *TennCare* as the safety net hospital, for underserved residents in southeast Tennessee. *Erlanger's* TennCare / Medicaid utilization and uncompensated care cost for the last three (3) fiscal years are presented below.

	TennCare / Medicaid Utilization %	Uncompensated Care Cost
FY 2013	21.0 %	$ 85.1 M
FY 2014	22.3 %	$ 86.2 M
FY 2015	25.0 %	$ 85.1 M

Notes
(3) TennCare / Medicaid utilization percentages are based on gross I/P charges derived from applicant's internal records.
(4) Uncompensated care cost estimates were derived from applicant's internal records as reported in the notes to the annual audited financial statements.
(5) Erlanger's fiscal year begins on July 1 of each year and ends on June 30 of the following year. For example, FY 2014 began on July 1, 2013, and ended on June 30, 2014.

Erlanger clearly shoulders significantly more than its proportionate share of the care rendered to vulnerable populations. The State Health Plan favors initiatives, like the project proposed herein, which help to foster access to the underserved.

In a press release on January 28, 2016, U.S. Senator Lamar Alexander said that public legislative hearings on

the mental health crisis in America are a "priority". As evidence, Sen. Alexander cited a 2014 national study by the *Substance Abuse & Mental Health Services Administration* which found that 1 in 5 adults had a mental health condition and 9.8 million adults had serious mental illness, such as schizophrenia, bipolar disorder or depression. Of these, nearly 60% of adults with mental illness did not receive care in 2014. Only about half of adolescents with a mental health condition received treatment. Further, in a study from 2010 - 2012, nearly 21% of adults in Tennessee reported having a mental illness.

Erlanger Medical Center has the only Level I trauma center, the only life-flight helicopter service, and the only children's hospital in the region. *Erlanger* is also the only provider in its service area of Level IV neonatal care and perinatal services. *Erlanger Health System* is committed to maintaining its mission of providing healthcare services to all citizen's regardless of ability to pay. Such services include inpatient care, obstetrics, surgical services, as well as emergency and outpatient services. A clear need exists to add behavioral halth to this complement of services.

Erlanger Health System also operates several other hospitals in Southeast Tennessee, as well as a network of physician offices and *Federally Qualified Health Centers* (hereinafter "FQHC"), so that patients may easily access needed services while also facilitating easy access to the broader healthcare delivery system.

3. *Economic Efficiencies*: The State's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the state's health care system.

Response

Erlanger Behavioral Health is a new project, therefore, it does not have historical financial data upon which to base a comparative evaluation of it's services with other providers of inpatient psychiatric services. However, below is a table of other Hamilton County,

Tennessee, providers of acute psychiatric services in the service area.

Hospital	Avg. Net Revenue Per I/P Admission
Parkridge Valley-Adult Hospital	$ 11,096
Parkridge Valley-Child/Adolescent Hospital	$ 8,835
Erlanger North Hospital	$ 10,593

Notes
(1) Information derived from Tennessee Joint Annual Reports for CY 2014.

Also, the net revenue per admission for Erlanger Behavioral Health, indicated by the *Projected Data Chart*, is as follows:

	Year 1	Year 2
Admissions	1,071	2,128
Net Operating Revenue	$ 4,670,977	$ 10,951,810
Net Revenue Per Admission	$ 4,361	$ 5,146

Comparative information for *Erlanger Medical Center* and other providers is below. The inpatient net revenue per admission for local providers in Chattanooga, Tennessee, is as follows.

Hospital	Avg. Net Revenue Per I/P Admission
Erlanger Medical Center	$ 11,431
Memorial Hospital	$ 11,924
Parkridge Medical Center	$ 13,565
Erlanger East Hospital	$ 6,019
Memorial Hospital - Hixson	$ 5,671
Parkridge East Hospital	$ 7,709

Notes
(1) Information derived from Tennessee Joint Annual Reports for CY 2014.

The net revenue per admission for another CON approved project by the *Health Services & Development Agency*, is as follows:

Hospital	CON No.	Avg. Net Revenue Per I/P Admission
Crestwyn Behavioral Health	CN1310-040	$ 6,785

Evidence of Erlanger's role as a low cost provider is illustrated with the initiation of the *Health Care*

Exchanges on January 1, 2014; *Blue Network E* enrolled over 10,000 uninsured and *Erlanger* is the only provider in this network. Further, an additional 7,000 people were enrolled in *Blue Network S* and *Erlanger* is one of only two providers in this network as well. It is anticipated that these additional health networks will generate sufficient volume to keep *Erlanger* cost efficient.

While offering more complex services and capabilities, *Erlanger* has net revenue per inpatient admission lower than other large area hospitals. *Erlanger Medical Center* is economically efficient, while incurring higher costs by offering more complex services including the only Level I trauma center, the only life-flight helicopter service, the only children's hospital, the only Level I trauma center, the only Regional Perinatal Center, and the only Level IV neonatal care in southeast Tennessee.[2]

4. ***Quality Of Care***: **Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.**

Response

Erlanger Health System, participates in periodic submission of quality related data to the *Centers For Medicare & Medicaid Services* through its *Hospital Compare* program and is also accredited by *The Joint Commission*. Further, *Erlanger Health System* has an internal program of *Medical Quality Improvement Committees* which continually monitor healthcare services to assure patients of the quality of care provided. The quality improvement program will include *Erlanger Behavioral Health*.

5. ***Health Care Workforce***: **The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.**

Response

Erlanger is an academic health system which has established strong long term relationships with the

2 Level IV as defined by the *Tennessee Perinatal Guidelines* as well as the *American College of Pediatrics*.

region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory care and pharmacy, to name a few. A number of regional universities offer Bachelor degree programs in nursing and physical therapy. Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine and Diagnostic Ultrasonography.

The *University of Tennessee - College of Medicine* is co-located at Erlanger and includes training of senior medical students on clinical rotation as well as graduate medical education for training of residents and advanced fellowships in various medical specialties, including surgical specialties, as outlined below.

Residency Programs
- Emergency Medicine
- Family Medicine
- Internal Medicine
- Obstetrics & Gynecology
- Orthopedic Surgery
- Pediatrics
- Plastic Surgery
- Surgery
- Urology
- Transitional Year

Fellowship Programs
- Orthopedic Trauma Surgery
- Surgical Critical Care
- Vascular Surgery
- Colon & Rectal Surgery
- Emergency Medicine
- Neuro-Interventional Surgery
- Ultrasound
- Cardiovascular Disease
- Gastroenterology (under development)
- Radiology (under development)
- Neurology (under development)

It should be noted that *Erlanger Health System* is currently in discussions with it's academic partner, the University of Tennessee - College of Medicine, to explore

the possibility of a graduate medical education and training residency program in Psychiatry.

Further, *Erlanger Health System* also participates with numerous schools that provide advanced training in the areas of nursing and allied health.

[End Of Responses To Principles Of Tennessee State Health Plan - 2011 Update, pages 5 - 13]

PSYCHIATRIC INPATIENT SERVICES

[Standards & Criteria, Effective - 2000, p. 25-26]

A. Need

1. The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of health and applying the data in Joint Annual Reports).

Response

The need for additional behavioral health services to serve the region has been evident at *Erlanger Health System* for some time, and the need for this project is clearly demonstrated by a detailed analysis of the service area. The defined service area is in need of an additional 219 inpatient psychiatric beds, based on the current bed need criteria.

Further, in the twelve (12) month period from Oct. 1, 2014 - Sep. 30, 2015, EHS had a total of 34,853 inpatient discharges, and of that there were 11,561 discharges with a mental health condition that needed to be treated. Further, of the 11,561 discharges with a mental condition, 6,468 of those patients were admitted through the Emergency Department. As such, Erlanger's emergency departments already provide mental health services to emergency patients with psychiatrists and clinical social workers.

As the 7th largest public health system in the nation, and the healthcare safety net for the region, *Erlanger Health System* is already the defacto provider of behavioral health services for those in need, serving those who are unable to access care elsewhere. Also, patients with cancer, cardiac or other complex medical conditions will benefit greatly from the provision of behavioral medicine provided on an outpatient basis. Having a "system of care" available to meet the needs of area residents is paramount.

The bed need calculation is derived from the current standard of thirty (30) beds per 100,000 population in the defined service area, less the current bed supply, to arrive at the "net need" for new beds in the service area. The 2016 total population for the Tennessee service area is 1,015,247; therefore, the Tennessee bed requirement is 305 (10.15 x 30), less the current bed supply of 395, yields a net over supply of 90 psychiatric beds, as demonstrated by the following table.

Psychiatric Beds - Current Supply -- Tennessee Service Area

	Total Psych / SA Beds	== Total Psych / Substance Beds For Service Area == Child & Youth Beds	Adult Psych Beds	Geriatric Beds	Substance Abuse Beds	Total Beds
Parkridge Valley Hospital - Chattanooga, TN	172	108	32	16	16	172
Erlanger North Hospital - Chattanooga, TN	12			12		12
Parkridge West Hospital - Jasper, TN	20		20			20
Moccasin Bend MHI - Chattanooga, TN	150		150			150
Skyridge Medical Center - Westside - Cleveland, TN	29		29			29
Southern Tenn Med Ctr - Winchester, TN	12		12			12
Total	395	108	243	28	16	395

(*) Bed data obtained from 2014 Tennessee *Joint Annual Reports.*

	Pop. 2016 Tenn.	Pop. 2020 Tenn.
Child / Adolescent (Age 0-17)	215,353	217,133
Adult (Age 18-64)	596,632	598,660
Geriatric (Age 65+)	203,262	233,652
	1,015,247	1,049,445

Total Est. Psychiatric Bed Need - 2016	305
Total Est. Psychiatric Bed Need - 2020	315

	Est. Requirement	Current Supply	Est. Need	Proposed Bed Mix
Child / Adolescent Beds - Est. Need - 2016	65	108	-43	18
Adult Beds - Est. Need - 2016	179	259	-80	46
Geriatric Beds - Est. Need - 2016	61	28	33	24
Total	305	395	-90	88

(**) Substance Abuse hospital beds included in Psychiatric beds.

However, this does not consider the bed need in the non-Tennessee portion of the service area. When taken into consideration, this presents an entirely different picture of the need for *Erlanger Behavioral Health*. The net bed need for the non-Tennessee service area is 167 additional psychiatric beds, as illustrated by the following table.

Psychiatric Beds - Current Supply -- Non - Tennessee Service Area

	Total Psych / SA Beds	== Total Psych / Substance Beds For Service Area == Child & Youth Beds	Adult Psych Beds	Geriatric Beds	Substance Abuse Beds	Total Beds
Hamilton Medical Center - Dalton, GA	7		7			7
Total	7	0	7	0	0	7

(*) Bed data obtained from *Certificates of Need* and other data sources.

	Pop. 2016 Non - Tenn.	Pop. 2020 Non - Tenn.
Child / Adolescent (Age 0-17)	135,139	134,478
Adult (Age 18-64)	345,781	343,305
Geriatric (Age 65+)	97,806	108,586
	578,726	586,369
Total Est. Psychiatric Bed Need - 2016	174	
Total Est. Psychiatric Bed Need - 2020	176	

	Est. Requirement	Current Supply	Est. Need	Proposed Bed Mix
Child / Adolescent Beds - Est. Need - 2016	41		41	18
Adult Beds - Est. Need - 2016	104	7	97	46
Geriatric Beds - Est. Need - 2016	29		29	24
Total	174	7	167	88

(**) Substance Abuse hospital beds included in Psychiatric beds.

There are currently a total of six (6) provider organizations delivering inpatient psychiatric and substance abuse/chemical dependency services at a total of eight (8) locations within the service area, for a total of 402 licensed inpatient beds.

The *combined* bed need calculation for the Tennessee and non-Tennessee portions of the service area, yields a net need for new inpatient psychiatric beds of 77 … total requirement of 479 (305 + 174), less the current bed supply of 402 (395 + 7).

Erlanger Behavioral Health will have a bed mix of twenty-four (24) Adult Psychiatric, twenty-four (24) Geriatric Psychiatric, eighteen (18) Child/Adolescent Psychiatric and twenty-two (22) Adult Chemical Dependency beds.

Erlanger Behavioral Health seeks to add seventy-six (76) new beds to the service area. *Erlanger North Hospital* will transfer it's current complement of twelve (12) licensed geriatric psychiatric beds to *Erlanger Behavioral Health* with approval and implementation of this CON application. This will be a total of eighty-eight (88) beds.

In a press release on January 28, 2016, U.S. Senator Lamar Alexander said that public legislative hearings on the mental health crisis in America are a "priority". As evidence, Sen. Alexander cited a 2014 national study by the *Substance Abuse & Mental Health Services Administration* which found that 1 in 5 adults had a mental health condition and 9.8 million adults had serious mental illness, such as schizophrenia, bipolar disorder or depression. Of these, nearly 60% of adults with mental illness did not receive care in 2014. Only about half of adolescents with a mental health condition received treatment. Further, in a study from 2010 – 2012, nearly 21% of adults in Tennessee reported having a mental illness.

In short, there is a critical need for additional inpatient psychiatric beds from the community need perspective, as well as *Erlanger's* institutional need perspective.

2. For adult programs, the age group of 18 years and older should be used in calculating the estimated total number of beds needed.

Response

As illustrated by the need information presented in item A-1, the bed need for adults is calculated based on the age group 18-64 years, and the geriatric need is calculated based on the age group over 65. Based on this methodology, the service area has a combined need for a total of 77 additional beds.

Erlanger Behavioral Health will have a bed mix of twenty-four (24) Adult Psychiatric, twenty-four (24) Geriatric Psychiatric, eighteen (18) Child/Adolescent Psychiatric and twenty-two (22) Adult Chemical Dependency beds.

3. **For child inpatient under age 13, and if adolescent program the age group of 13-17 should be used.**

Response

As illustrated by the need information presented in item A-1, the bed need for child/adolescents is calculated based on the age group 0-17 years.

Erlanger Behavioral Health will have a bed mix of eighteen (18) child/adolescent beds.

4. **These estimates for total need should be adjusted by the existing staffed beds operating in the area as counted by the Department of Health in the Joint Annual Report.**

Response

As illustrated by the need information presented in item A-1, the bed need has been adjusted by the existing staffed beds operating in the service area, as reported in the 2014 Tennessee Joint Annual Reports for hospitals.

B. Service Area

1. **The geographic service area should be reasonable and based on an optimal balance between population density and service proximity or the Community Service Agency.**

Response

The service area for this project is defined as Hamilton County, Tennessee, and the counties that surround Hamilton County in Tennessee, Georgia, Alabama and North

Carolina. The service area consists of a total of thirty (30) contiguous counties in the four (4) state geography. A complete list of the counties which comprise the service area is attached to this CON application.

This geography represents the primary, secondary and tertiary service areas for *Erlanger Medical Center*. As such, the service area is reasonable and provides optimal balance between population density and service proximity.

2. **The relationship of the socio-demographics of the service area, and the projected population to receive services, should be considered. The proposal's sensitivity to, and responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, and those needing services involuntarily.**

Response

Erlanger Behavioral Health will serve adolescents and adults of all ages without discrimination, and also without regard to gender, ethnicity or ability to pay for services.

Erlanger Behavioral Health will serve all patients in need of psychiatric and substance abuse services regardless of ability to pay. Further, patients with TennCare/Medicaid coverage will be admitted and served, as will charity patients.

Erlanger Behavioral Health will accept involuntary admissions from the judicial system regardless of ability to pay.

C. Relationship To Existing Applicable Plans

1. **The proposal's relationship to policy as formulated in state, city, county, and/or regional plans and other documents should be a significant consideration.**

Response

The *Tennessee Guidelines For Growth*, which have already been addressed, identify several factors pertaining to this CON application. The *Guidelines* support delivery of services in the most medically appropriate setting, which goal this CON application serves. The *Guidelines* support those CON applications which provide services to the elderly, which goal this CON application serves. The *Guidelines* indicate that preference will be given to patient accessibility and availability, which goal this CON application serves.

According to the *Tennessee State Health Plan* "mental health problems are more prevalent in Tennessee than the national average", while "the prevalence of mental health problems and illnesses is often underestimated" … but "despite improvements in our understanding of mental health problems and illnesses often do not get treatment".[3] This CON application seeks to serve this significant need.

2. The proposal's relationship to underserved geographic areas as identified in state, city, county and/or regional plans and other documents should be a significant consideration.

Response

The extensive service area extends from Chattanooga across rural parts of four (4) States, and includes numerous counties which are designated by the *Health Resources & Services Administration* as *Medically Underserved Areas* ("MUA's"). The medically underserved area includes Chattanooga and Hamilton County, Tennessee. Further, every county in the defined service area is classified as a *Health Professional Shortage Area* ("HPSA") for mental health, and this also includes Chattanooga and Hamilton County, Tennessee.

3. The impact of the proposal on similar services supported by state appropriations should be assessed and considered.

Response

3 *Tennessee State Health Plan*, November, 2009, page 25.

It is noted that *Moccasin Bend Mental Health Institute* ("MBMHI") is a State funded psychiatric hospital in Chattanooga, Hamilton County, Tennessee. However, this project is not expected to have any impact on *MBMHI* due to the nature of the patients which this provider accepts. From the website, the mission of *MBMHI* is identified as:

> "The mission of *MBMHI* is to provide quality psychiatric services to individuals with a severe and persistent mental illness."

Also, *MBMHI's* service area is also much broader than the service area proposed. The *MBMHI* service area is 52 counties which serves all of East Tennessee extending North to the Kentucky and Virginia state lines.

MBMHI has a total of 150 acute psychiatric beds, which includes two (2) long term care units. Further, MBMHI identifies it's service area as fifty-two (52) counties in East Tennessee, this includes thirty-four (34) counties in Tennessee that are not in the service area for *Erlanger Behavioral Health*. Because *MBMHI* treats those who are severely mentally ill, it is not expected that this project will impact it's services.

4. The proposal's relationship to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, should be assessed and considered.

Response

As stated in response to item B-2, *Erlanger Behavioral Health* will accept voluntary patients, as well as involuntary patients from the judicial system. Acute mental health patients will be served at this facility, not long-term patients on a residential basis.

5. The degree of projected financial participation in the Medicare and TennCare programs should be considered.

Response

As stated in response to item B-2, *Erlanger Behavioral Health* will participate in both the Medicare and TennCare programs.

D. Relationship To Existing Similar Services In The Area

1. The area's trends in occupancy and utilization of similar services should be considered.

Response

The utilization trend for psychiatric and substance abuse beds is presented below. Utilization for CY 2014 suggests that not all populations including special needs, are receiving these necessary services.

SUPPLEMENTAL #2
March 31, 2016
11:59 am

Psychiatric Beds - Utilization Trend

	% Change 2011-2014	Actual Discharges 2014	2013	2012	2011
Parkridge Valley Adult - Chattanooga, TN	100.0%	2,070	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN	-61.0%	1,211	3,004	3,073	3,106
Parkridge Medical Center - Chattanooga, TN	-100.0%	-	-	258	291
Erlanger North Hospital - Chattanooga, TN	367.9%	262	281	268	56
Moccasin Bend MHI - Chattanooga, TN	40.3%	2,999	2,768	2,340	2,138
Parkridge West Hospital - Jasper, TN	204.9%	497	465	473	163
Skyridge Medical Center - Westside - Cleveland, TN	-0.4%	840	928	959	843
Southern Tenn Med Ctr - Winchester, TN	16.4%	170	86	135	146
Total	19.4%	8,049	7,532	7,506	6,743

	Total Psych / SA Beds	Annual Pt. Days Available		Actual Patient Days 2014	2013	2012	2011
Parkridge Valley Adult - Chattanooga, TN	64	23,360	100.0%	12,420	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN	108	39,420	-22.6%	30,203	44,968	39,153	39,012
Parkridge Medical Center - Chattanooga, TN	11	4,015	-100.0%	-	-	2,793	3,054
Erlanger North Hospital - Chattanooga, TN	12	4,380	-1.7%	3,628	3,761	3,746	3,692
Moccasin Bend MHI - Chattanooga, TN	150	54,750	34.6%	49,875	47,908	37,970	37,055
Parkridge West Hospital - Jasper, TN	20	7,300	222.9%	4,930	5,055	5,278	1,527
Skyridge Medical Center - Westside - Cleveland, TN	29	10,585	40.6%	2,203	1,038	1,362	1,567
Southern Tenn Med Ctr - Winchester, TN	12	4,380	-6.3%	4,170	3,916	4,421	4,448
Total	406	148,190	18.9%	107,429	106,646	94,723	90,355

		Occupancy Rate 2014	2013	2012	2012
Parkridge Valley Adult - Chattanooga, TN	100.0%	53.2%	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN	-22.6%	76.6%	114.1%	99.3%	99.0%
Parkridge Medical Center - Chattanooga, TN	-100.0%	-	-	69.6%	76.1%
Erlanger North Hospital - Chattanooga, TN	-1.8%	82.8%	85.9%	85.5%	84.3%
Moccasin Bend MHI - Chattanooga, TN	34.6%	91.1%	87.5%	69.4%	67.7%
Parkridge West Hospital - Jasper, TN	223.0%	67.5%	69.2%	72.3%	20.9%
Skyridge Medical Center - Westside - Cleveland, TN	40.5%	20.8%	9.8%	12.9%	14.8%
Southern Tenn Med Ctr - Winchester, TN	-6.3%	95.2%	89.4%	100.9%	101.6%
Total	18.9%	72.5%	72.0%	63.9%	61.0%

NOTES
(1) Utilization data obtained from Tennessee *Joint Annual Reports*.
(2) Parkridge Valley moved it's Adult & Geriatric beds to a new campus in 2014.
(3) Utilization data not available for Hamilton Medical Center in Dalton, Georgia.

Nationally, utilization of Psychiatric services is expected to increase over the next ten (10) years between 2015 and 2025, with overall growth for inpatient service at a rate of 5% and overall growth for outpatient service at a rate of 19%. Sg2, a national healthcare consultancy firm, provides the following detail by growth factor:

Factor	Inpatient	Outpatient
Population	7%	8%
Epidemiology	1%	3%
Economy	.5%	1%
Policy	.2%	1%
Innovation & Tech.	-2%	1%

System Of Care	-2%	4%
Total	5%	19%

Notes
(1) Information obtained from Sg2, *2015 Behavioral Health Landscape - Introduction To The Forecast*, p. 6.

In addition, Sg2 estimates that 68% of those with a mental disorder also have 1 or more medical conditions. Further, 29% of adults with a chronic condition have a comorbid mental health disorder.

2. Accessibility to specific special need groups should be an important factor.

Response

Erlanger Behavioral Health will serve adolescents and adults of all ages without discrimination, and also without regard to gender, ethnicity or ability to pay for services.

Disparity in mental health status and mental health care are critical in determining the greatest need. Specifically, "Blacks, Latino's and Asian Americans are over represented in populations that are particularly at risk for mental health disorders. Additionally, minority individuals may experience symptoms that are undiagnosed, under-diagnosed, or mis-diagnosed for cultural, linguistic, or historical reasons. The lack of attention to the mental and behavioral health needs of racial and ethnic minorities and the inadequate provision of culturally and linguistically appropriate mental health care in racial and ethnic minority communities demonstrates a clear need … to close the gap in care."

Erlanger Behavioral Health will serve all patients in need of psychiatric and substance abuse services regardless of ability to pay. Further, patients with TennCare/Medicaid coverage will be admitted and served, as will charity patients.

Erlanger Behavioral Health will accept involuntary admissions from the judicial system regardless of ability to pay.

E. Feasibility

The ability of the applicant to meet Tennessee Department of Mental Health licensure requirements (related to personnel and staffing for psychiatric inpatient facilities) should be considered.

Response

Erlanger Behavioral Health will meet all licensure requirements of the *Tennessee Department of Mental Health* related to personnel and staffing for inpatient psychiatric hospitals.

[End Of Responses To Standards & Criteria For Psychiatric Inpatient Services, 2000, page 26-26]

GENERAL QUESTIONS CONCERNING NEED, ECONOMIC FEASIBILITY & CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE

(I.) *NEED*

1. Describe the relationship of this proposal toward the implementation of the State Health Plan, Teneessee's Health: Guidelines For Growth.

(a) Please provide a response to each criterion and standard in Certificate Of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

Response

This project is consistent with the *Principles Of The Tennessee State Health Plan* as stated in the 2011 update ("Principles"). *Applicant* has addressed each of the Principles.

(b) Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c).

Response

** Not applicable. **

2. Describe the relationship of this proposal to the applicant facility's long range development plans, if any.

Response

Erlanger Health System currently holds a CON for expansion of *Erlanger East Hospital* (No. CN0405-047AE); and a CON to modernize and upgrade the surgical facilities at *Erlanger Medical Center* (No. CN1207-034A); a CON was approved for *Erlanger East Hospital* to initiate a satellite radiation therapy service along with the relocation of a Linear Accelerator from *Erlanger Medical Center* (no. CN1412-048); a CON application was approved to upgrade the Cardiac Catheterization Laboratory for *Erlanger East Hospital* from a diagnostic catheterization laboratory to an interventional / therapeutic laboratory (No. CN1502-005). Also, a CON application (No. CN1601-002) is currently pending with the *Health Services & Development Agency* to add a Level III NICU at *Erlanger East Hospital*.

The goal for *Erlanger Health System* is to provide a comprehensive system of care comprised of unduplicated services while also serving those who are currently under served and/or those who do not have the ability to pay for their services. As such, *Erlanger Behavioral Health* is part of a long term plan to make services more accessible.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit maps on 8 ½" x 11" sheets of white paper marked only with ink detectable by a standard photocopier (i.e-no highlighters, pencils, etc.).

Response

The service area for this project is defined as Hamilton County, Tennessee, and the counties that surround Hamilton County in Tennessee, Georgia, Alabama and North Carolina. The service area consists of a total of thirty (30) contiguous counties in the four (4) state geography. A complete list of the counties which comprise the service area is attached to this CON application.

This geography represents the same primary, secondary and tertiary service areas as *Erlanger Medical Center*. Therefore, the service area is reasonable and provides balance between population density and service proximity. A map showing the service area is attached to this CON application.

4. A. Describe the demographics of the population to be served by this proposal.

Response

The State of Tennessee has a TennCare enrollment of 20.0%, compared to the Tennessee service area for this project which is 21.7%. The population over age 65 is expected to grow by 6.8% for the service area between 2016 and 2020, compared to the Tennessee growth rate of 3.2% … while the total population is expected to grow by only 3.0% for the service area, compared to 3.7% for Tennessee. Briefly stated, this illustrates that the over 65 population is growing at a faster rate than the total population for the Tennessee service area, when compared to the State of Tennessee.

The need for additional behavioral health services to serve the region has been evident at *Erlanger Health System* for some time, and the need for this project is clearly demonstrated by a detailed analysis of the service area. The defined service area is in need of an additional 219 inpatient psychiatric beds, based on the current bed need criteria.

In the twelve (12) month period from Oct. 1, 2014 – Sep. 30, 2015, EHS had a total of 34,853 inpatient discharges, and of that there were 11,561 discharges with a mental health condition that needed to be treated.

Further, of the 11,561 discharges with a mental condition, 6,468 of those patients were admitted through the Emergency Department. As the 7th largest public health system in the nation, and the healthcare safety net for the region, *Erlanger Health System* is already the defacto provider of behavioral health services for those in need, serving those who are unable to access care elsewhere. Also, patients with cancer, cardiac or other complex medical conditions will benefit greatly from the provision of behavioral medicine provided on an outpatient basis. Having a "system of care" available to meet the needs of area residents is paramount.

A summary of demographic information appears below which outlines TennCare enrollment, changes in population, and that portion which is below the Federal poverty level within the service area, by county compared to the State of Tennessee.

	Hamilton	Bradley	Marion	Grundy	Sequatchie	Bledsoe
Current Year (2016) - Age 65+	61,073	17,879	5,763	3,021	3,195	2,628
Projected Year (2020) - Age 65+	69,752	20,381	6,584	3,339	3,896	2,955
Age 65+ - % Change	14.2%	14.0%	14.2%	10.5%	21.9%	12.4%
Age 65+ - % Total	17.1%	16.9%	20.2%	22.4%	20.2%	19.8%
Total Pop. - 2016	356,156	105,549	28,585	13,470	15,835	13,273
Total Pop. - 2020	368,666	109,706	28,633	13,263	16,943	13,481
Total Pop. - % Change	3.5%	3.9%	0.2%	-1.5%	7.0%	1.6%
Median Age	40	39	43	43	42	43
Median Household Income	$47,880	$41,575	$40,998	$26,856	$42,182	$38,450
TennCare Enrollees	69,738	22,933	7,395	4,921	4,135	3,405
TennCare Enrollees As % Of Total Pop.	19.6%	21.7%	25.9%	36.5%	26.1%	25.7%
Persons Below Poverty Level	56,629	18,471	5,889	3,516	2,961	3,783
Persons Below Poverty Level As % Of Total Pop.	15.9%	17.5%	20.6%	26.1%	18.7%	28.5%

	Rhea	Meigs	McMinn	Polk	Franklin	Coffee
Current Year (2016) - Age 65+	6,589	2,677	11,089	3,680	8,752	10,225
Projected Year (2020) - Age 65+	7,571	3,151	12,650	4,134	9,972	11,573
Age 65+ - % Change	14.9%	17.7%	14.1%	12.3%	13.9%	13.2%
Age 65+ - % Total	19.4%	21.9%	20.4%	21.1%	20.8%	18.3%
Total Pop. - 2016	33,934	12,221	54,449	17,442	42,097	55,932
Total Pop. - 2020	35,216	12,462	55,724	17,812	42,681	57,865
Total Pop. - % Change	3.8%	2.0%	2.3%	2.1%	1.4%	3.5%
Median Age	41	44	43	43	42	40
Median Household Income	$37,512	$33,061	$39,644	$39,434	$42,663	$39,656
TennCare Enrollees	9,466	3,365	12,815	1,052	8,200	13,894
TennCare Enrollees As % Of Total Pop.	27.9%	27.5%	23.5%	6.0%	19.5%	24.8%
Persons Below Poverty Level	7,465	2,542	9,474	3,541	6,946	9,397
Persons Below Poverty Level As % Of Total Pop.	22.0%	20.8%	17.4%	20.3%	16.5%	16.8%

	Warren	Van Buren	Monroe	Cumberland	Loudon	Roane	Service Area	State Of Tennessee
Current Year (2016) - Age 65+	7,350	1,313	10,398	19,871	15,089	12,670	203,262	1,091,516
Projected Year (2020) - Age 65+	8,233	1,554	12,384	23,106	17,908	14,509	233,652	1,266,295
Age 65+ - % Change	12.0%	18.4%	19.1%	16.3%	18.7%	14.5%	15.0%	16.0%
Age 65+ - % Total	18.0%	23.2%	21.7%	32.1%	27.8%	22.8%	20.0%	16.0%
Total Pop. - 2016	40,872	5,651	47,980	61,910	54,261	55,630	1,015,247	6,812,005
Total Pop. - 2020	41,446	5,686	50,062	65,575	57,923	56,301	1,049,445	7,108,031
Total Pop. - % Change	1.4%	0.6%	4.3%	5.9%	6.7%	1.2%	3.4%	4.3%
Median Age	40	46	43	50	47	46	43	38
Median Household Income	$34,592	$34,250	$37,202	$38,350	$50,619	$41,726	$39,258	$44,621
TennCare Enrollees	11,584	1,410	12,154	13,158	9,459	12,068	221,152	1,331,838
TennCare Enrollees As % Of Total Pop.	28.3%	25.0%	25.3%	21.3%	17.4%	21.7%	21.8%	19.6%
Persons Below Poverty Level	7,766	1,164	9,884	10,277	7,379	10,013	177,097	1,246,597
Persons Below Poverty Level As % Of Total Pop.	19.0%	20.6%	20.6%	16.6%	13.6%	18.0%	17.4%	18.3%

B. The special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response

As a member facility of *Erlanger Health System*, *Erlanger Behavioral Health* is a component of the safety net

for southeast Tennessee. Often the only hospital which low-income people, minorities, and other underserved populations can turn to for treatment is *Erlanger*. In order to assure the continued viability of its mission as the safety net provider, *Erlanger Health System* continually strives to provide services that are medically appropriate, least intensive (restrictive), and provided in the most cost-effective health care setting.

Disparity in mental health status and mental health care are critical in determining the greatest need. Specifically, "Blacks, Latino's and Asian Americans are over represented in populations that are particularly at risk for mental health disorders. Additionally, minority individuals may experience symptoms that are undiagnosed, under-diagnosed, or mis-diagnosed for cultural, linguistic, or historical reasons. The lack of attention to the mental and behavioral health needs of racial and ethnic minorities and the inadequate provision of culturally and linguistically appropriate mental health care in racial and ethnic minority communities demonstrates a clear need … to close the gap in care."

Erlanger Behavioral Health is easily accessible to patients in Chattanooga, as well as Hamilton and surrounding counties in the service area. The hospital can be easily accessed via public transportation. Proximal state and interstate highways provide easy access from Tennessee, Georgia, Alabama and North Carolina.

The distance from *Erlanger Medical Center* to *Erlanger Behavioral Health* is 1.1 miles, with a drive time of 2 minutes, as evidenced by the map below. Public transportation is easily accessible to the proposed location. Further, U.S. Highway 27 and U.S. Interstate 24 are major roads in downtown Chattanooga and are within 2.5 miles of the proposed location.

Erlanger has also been responsive to the needs of employees and families of new businesses like VW, Amazon and Wacker Chemical which have generated thousands of new jobs in the area. The proposed project will help ensure that the service area population have access to services and facilities consistent with their needs and evolving industry standards.

5. Describe the existing or certified services, including approved but unimplemented CON's, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utlilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

Response

There are currently no outstanding CON's for inpatient psychiatric facilities in the service area. The utilization trend for psychiatric and substance abuse beds suggests that not all populations, including special needs, are receiving these necessary services.

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Psychiatric Beds - Utilization Trend

	% Change 2011-2014	Actual Discharges 2014	2013	2012	2011
Parkridge Valley Adult - Chattanooga, TN	100.0%	2,070	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN	-61.0%	1,211	3,004	3,073	3,106
Parkridge Medical Center - Chattanooga, TN	-100.0%	-	-	258	291
Erlanger North Hospital - Chattanooga, TN	367.9%	262	281	268	56
Moccasin Bend MHI - Chattanooga, TN	40.3%	2,999	2,768	2,340	2,138
Parkridge West Hospital - Jasper, TN	204.9%	497	465	473	163
Skyridge Medical Center - Westside - Cleveland, TN	-0.4%	840	928	959	843
Southern Tenn Med Ctr - Winchester, TN	16.4%	170	86	135	146
Total	19.4%	8,049	7,532	7,506	6,743

	Total Psych / SA Beds	Annual Pt. Days Available		Actual Patient Days 2014	2013	2012	2011
Parkridge Valley Adult - Chattanooga, TN	64	23,360	100.0%	12,420	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN	108	39,420	-22.6%	30,203	44,968	39,153	39,012
Parkridge Medical Center - Chattanooga, TN	11	4,015	-100.0%	-	-	2,793	3,054
Erlanger North Hospital - Chattanooga, TN	12	4,380	-1.7%	3,628	3,761	3,746	3,692
Moccasin Bend MHI - Chattanooga, TN	150	54,750	34.6%	49,875	47,908	37,970	37,055
Parkridge West Hospital - Jasper, TN	20	7,300	222.9%	4,930	5,055	5,278	1,527
Skyridge Medical Center - Westside - Cleveland, TN	29	10,585	40.6%	2,203	1,038	1,362	1,567
Southern Tenn Med Ctr - Winchester, TN	12	4,380	-6.3%	4,170	3,916	4,421	4,448
Total	406	148,190	18.9%	107,429	106,646	94,723	90,355

		Occupancy Rate 2014	2013	2012	2012
Parkridge Valley Adult - Chattanooga, TN	100.0%	53.2%	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN	-22.6%	76.6%	114.1%	99.3%	99.0%
Parkridge Medical Center - Chattanooga, TN	-100.0%	-	-	69.6%	76.1%
Erlanger North Hospital - Chattanooga, TN	-1.8%	82.8%	85.9%	85.5%	84.3%
Moccasin Bend MHI - Chattanooga, TN	34.6%	91.1%	87.5%	69.4%	67.7%
Parkridge West Hospital - Jasper, TN	223.0%	67.5%	69.2%	72.3%	20.9%
Skyridge Medical Center - Westside - Cleveland, TN	40.5%	20.8%	9.8%	12.9%	14.8%
Southern Tenn Med Ctr - Winchester, TN	-6.3%	95.2%	89.4%	100.9%	101.6%
Total	18.9%	72.5%	72.0%	63.9%	61.0%

NOTES
(1) Utilization data obtained from Tennessee *Joint Annual Reports*.
(2) Parkridge Valley moved it's Adult & Geriatric beds to a new campus in 2014.
(3) Utilization data not available for Hamilton Medical Center in Dalton, Georgia.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Response

As a new facility, *Erlanger Behavioral Health* does not have historical utilization data to report, however, projected utilization data is presented below.

	Year 1	Year 2
Admissions	1,071	2,128
Patient Days	8,798	17,481
Average Daily Census	24.1	47.9

(II.) *ECONOMIC FEASIBILITY*

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

- **All projects should have a project cost of at least $ 3,000 on Line F (minimum CON filing fee). CON filing fee should be calculated from Line D. (See application instructions for filing fee.)**

- **The cost of any lease should be based on fair market value or the total amount of lease payments over the initial term of the lease, whichever is greater.**

- **The cost of fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.**

- **For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.**

Response

The *Project Cost Chart* has been completed on the next page.

SUPPLEMENTAL #1
March 28, 2016
11:49 am

PROJECT COST CHART

A.	Construction And Equipment Acquired By Purchase.	
1.	Architecural And Engineering Fees	1,632,600
2.	Legal, Administrative, Consultant Fees (Excluding CON Filing Fees)	50,000
3.	Acquisition Of Site	825,000
4.	Preparation Of Site	1,800,000
5.	Construction Costs	18,720,000
6.	Contingency Fund	1,000,000
7.	Fixed Equipment (Not Included In Construction Contract)	350,000
8.	Moveable Equipment (List all equipment over $ 50,000)	
9.	Other (Specify) Dietary equipment & misc. start-up costs.	690,000
B.	Acquisition By Gift, Donation, Or Lease.	
1.	Facility (inclusive of building and land)	0
2.	Building Only	0
3.	Land Only	0
4.	Equipment (Specify) _____	0
5.	Other (Specify) _____	0
C.	Financing Costs And Fees.	
1.	Interim Financing	0
2.	Underwriting Costs	0
3.	Reserve For One Year's Debt Service	0
4.	Other (Specify) _____	0
D.	Estimated Project Cost (A + B + C)	25,067,600
E.	CON Filing Fee	45,000
F.	Total Estimated Project Cost (D + E)	25,112,600

SUPPLEMENTAL #5
April 27, 2016
10:10 am

2. Identify the funding sources for this project.

a. Please check the applicable item(s) below and briefly summarize how the project will be financed. (Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)

X A. Commercial Loan -- Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions.

___ B. Tax - Exempt Bonds -- Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance.

___ C. General obligation bonds -- Copy of resolution from issuing authority or minutes from the appropriate meeting.

___ D. Grants -- Notification of intent form for grant application or notice of grant award.

___ E. Cash Reserves - Appropriate documentation from Chief Financial Officer.

___ F. Other - Identify and document funding from all other sources.

Response

The project will be funded by *Acadia Healthcare*. See letter attached to this CON application.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services And Development Agency.

Response

Cost per square foot for hospital construction is shown below for HSDA approved projects from 2012 - 2014.

HSDA -- Hospital Construction Cost Per Square Foot
Approved Projects -- 2012 - 2014

	Renovated Construction	New Construction	Total Construction
1st Quartile	$ 110.98 / SF	$ 224.09 / SF	$ 156.78 / SF
Median	$ 192.46 / SF	$ 259.56 / SF	$ 227.88 / SF
3rd Quartile	$ 297.82 / SF	$ 296.52 / SF	$ 298.66 / SF

An analysis of the cost per square foot with similar projects in Tennessee is below.

Facility	CON Number	Cost Per Square Foot
Crestwyn Behavioral Health	CN1310-040	$ 244.85
SBH-Kingsport, LLC	CN1312-050	$ 153.00

The construction cost of $ 18,720,000 for this project, along with the estimated 69,000 SF, will yield cost estimate per SF for the *Erlanger Behavioral Health* facility of $ 271.30. This cost is reasonable when compared to the projects above, particularly when considered in relation to time and location.

4. Complete Historical and Projected Data Charts on the following two pages - *Do not modify the Charts provided or submit Chart substitutions* ! Historical Data Chart represents revenue and expense information for the last *three* (3) years for which complete information is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the *Proposal Only* (i.e.-if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

Response

Please note that since *Erlanger Behavioral Health* is a new hospital, there is no historical financial information to report. However, we have provided the historical financial information for *Erlanger Health System*. The *Historical Data Chart* and *Projected Data Chart* have been completed. The detail for *Other Expenses* on the *Historical Data Chart* is attached to this CON application.

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month).

		Year – 2013	Year – 2014	Year – 2015
A.	Utilization Data	29,066	30,394	33,340
	(Specify Unit Of Measure) I/P Admits			
B.	Revenue From Services To Patients			
	1. Inpatient Services	951,407,744	1,011,698,242	1,182,962,344
	2. Outpatient Services	638,832,332	723,658,840	830,030,436
	3. Emergency Services	122,125,184	147,183,286	171,845,957
	4. Other Operating Revenue	33,499,831	36,036,026	32,126,111
	(Specify) Home Health, POB Rent, etc.			
	Gross Operating Revenue	1,745,865,091	1,918,576,394	2,216,964,846
C.	Deductions From Operating Revenue			
	1. Contractual Adjustments	997,920,752	1,105,607,716	1,317,441,010
	2. Provision For Charity Care	102,150,881	110,213,778	92,392,901
	3. Provision For Bad Debt	74,808,470	84,222,955	93,878,274
	Total Deductions	1,174,880,103	1,300,044,449	1,503,712,185
	NET OPERATING REVENUE	570,984,988	618,531,945	713,252,663
D.	Operating Expenses			
	1. Salaries And Wages	275,109,764	276,229,682	270,118,412
	2. Physician's Salaries And Wages	36,117,461	42,290,749	76,375,201
	3. Supplies	78,028,042	82,925,430	93,104,628
	4. Taxes	536,994	566,101	558,754
	5. Depreciation	27,373,556	26,732,222	25,647,102
	6. Rent	5,341,116	5,209,326	5,816,951
	7. Interest – Other Than Capital	0	0	0
	8. Management Fees:			
	a. Fees To Affiliates			
	b. Fees To Non-Affiliates			
	9. Other Expenses	156,440,656	166,565,645	193,745,905
	(Specify) Insurance, Purch. Svcs., etc.			
	Total Operating Expenses	578,947,589	600,519,155	665,366,953
E.	Other Revenue (Expenses) - Net			
	(Specify)			
	NET OPERATING INCOME (LOSS)	(7,962,601)	18,012,789	47,885,710
F.	Capital Expenditures			
	1. Retirement Of Principal	7,900,842	8,048,272	15,492,190
	2. Interest	8,971,728	8,258,717	9,507,644
	Total Capital Expenditures	16,872,570	16,306,989	24,999,834
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	(24,835,171)	1,705,800	22,885,876

SUPPLEMENTAL #1
March 28, 2016
11:49 am

PROJECTED DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month).

		Year 1	Year 2
A.	Utilization Data (Specify Unit Of Measure) Pt. Days	8,798	17,481
B.	Revenue From Services To Patients		
	1. Inpatient Services	11,870,450	26,516,061
	2. Outpatient Services	121,350	339,270
	3. Emergency Services	-	-
	4. Other Operating Revenue	10,000	12,000
	Gross Operating Revenue	12,001,800	26,867,331
C.	Deductions From Operating Revenue		
	1. Contractual Adjustments	6,727,381	15,027,536
	2. Provision For Charity Care		
	3. Provision For Bad Debt	603,442	887,985
	Total Deductions	7,330,823	15,915,521
	NET OPERATING REVENUE	4,670,977	10,951,810
D.	Operating Expenses		
	1. Salaries And Wages	3,432,825	6,124,604
	2. Physician's Salaries And Wages	172,335	314,512
	3. Supplies	319,545	483,451
	4. Taxes		
	5. Depreciation	812,831	841,574
	6. Rent	24,000	24,720
	7. Interest - Other Than Capital		
	8. Management Fees:		
	a. Fees To Affiliates	93,419	219,036
	b. Fees To Non-Affiliates		
	9. Other Expenses (Specify) Service Contracts	1,027,943	2,829,476
	Total Operating Expenses	5,882,898	10,837,373
E.	Other Revenue (Expenses) – Net (Specify)		
	NET OPERATING INCOME (LOSS)	(1,211,921)	114,438
F.	Capital Expenditures		
	1. Retirement Of Principal		
	2. Interest		
	Total Capital Expenditures		
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	(1,211,921)	114,438

5. **Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.**

Response

Following are the average charge amounts per patient.

Average Gross Charge	$ 11,206
Average Deduction From Revenue	$ 6,845
Average Net Revenue	$ 4,361
Average Deduction From Revenue	
Medicare	$ 7,759
TennCare / Medicaid	$ 12,820
Average Net Revenue	
Medicare	$ 7,759
TennCare / Medicaid	$ 7,422

6. A. **Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges of projects that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.**

Response

A charge master file for *Erlanger Behavioral Health* has not yet been developed. However, net revenue per admission as indicated by the *Projected Data Chart* is as follows:

	Year 1	Year 2
Admissions	1,071	2,128
Net Operating Revenue	$ 4,670,977	$ 10,951,810
Net Revenue Per Admission	4,361	$ 5,146

It is anticipated that *Erlanger Behavioral Health* will revise it's charges annually once it opens for operation. Generally, proposed charges will be in line with other like providers.

B. **Compare the proposed charges to those of other**

facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services And Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response

Erlanger Behavioral Health does not have any historical financial data upon which to base a comparative evaluation of it's services with other providers of inpatient psychiatric services. However, below is a table of other Hamilton County, Tennessee, providers of acute psychiatric services in the service area.

Hospital	Avg. Net Revenue Per I/P Admission
Parkridge Valley-Adult Hospital	$ 11,096
Parkridge Valley-Child/Adolescent Hospital	$ 8,835
Erlanger North Hospital	$ 10,593

Notes
(1) Information derived from Tennessee Joint Annual Reports for CY 2014.

Also, the net revenue per admission for the new hospital, indicated by the *Projected Data Chart*, is as follows:

	Year 1	Year 2
Admissions	1,071	2,128
Net Operating Revenue	$ 4,670,977	$ 10,951,810
Net Revenue Per Admission	$ 4,361	$ 5,146

The net revenue per admission for another CON approved project by the *Health Services & Development Agency*, is as follows:

Hospital	CON No.	Avg. Net Revenue Per I/P Admission
Crestwyn Behavioral Health	CN1310-040	$ 6,785

7. Discuss how projected utilization rates will be sufficient to maintain cost effectiveness.

Response

Despite the significant need demonstrated in this CON application, *Erlanger Behavioral Health* has been conservative by estimating an average daily census of 24.1 in year 1 of the project, and an average daily census of 47.9 in year 2. As the *Projected Data Chart* demonstrates, a positive financial result will be achieved beginning in year 2. As the average daily census increases over subsequent years, the efficiency gained by higher utilization will enable cost effectiveness to be sustained.

8. Discuss how financial viability will be ensured within two (2) years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

Response

As demonstrated by the *Projected Data Chart*, the project has a positive financial result beginning in year 2 of the project. Year 1 financial results reflect start-up costs. For example, year 1 includes 10 months of revenue but 12 months of expense for training and onboarding of new staff members during start-up.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

Response

Erlanger Behavioral Health, will apply to CMS for participation in the following Federal / State programs.

Federal	Medicare
State	BlueCare TennCare Select AmeriGroup Community Care

Anticipated revenue (gross charges) from Federal and State sources during year 1 of the project, is as follows.

Medicare	$ 3,917,249
TennCare	$ 3,086,317
	$ 7,003,566

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

Response

Please note that since *Erlanger Behavioral Health* is a new hospital, there is no historical financial information to report. However, copies of the following financial statements for *Erlanger Health System* are attached to this CON application.

Interim Balance Sheet & Income Statement	Dec. 30, 2015
Audited Financial Statements	June 30, 2015

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to,

A. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If developments of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

Response

A number of alternatives were considered and deemed not to be feasible. These alternatives included locating the proposed project at *Erlanger North Hospital* where a twelve (12) bed Geriatric-Psychiatric unit is already located, however, this was not feasible due to the topography of the site and the inability to accommodate the proposed plan in a functionally efficient manner. Also, cost was anticipated to be higher given the need for extensive site improvements. We next evaluated the *Erlanger Medical Center* campus, however, available land on the main campus is expected to be utilized for construction of a new/replacement children's hospital and for a children's ambulatory care building, leaving little to no space for the new behavioral health hospital.

Consideration was given to use of the Hamilton County Health Department site adjacent to *Erlanger Medical Center*, however, this building and services would need to be relocated and replaced, increasing project cost. Further, other land contiguous to the main campus is expected to be utilized by the city for extension of Central Avenue, connecting with Amnicola Highway. While this location is expected to reduce travel time to *Erlanger's* trauma center, insufficient space would remain for this project. Sites owned by the city and county were also evaluated, and we met and discussed the proposed project with the Chamber of Commerce and elected officials; however, these sites are contemplated to be used for higher density industrial development.

We also considered not developing the proposed project but rejected this alternative given the identified need and number of patients currently served. In the end, selection of a site located two minutes' drive from the main campus was considered the best option. The site is flat and sufficient to accommodate the proposed project.

As *the* safety net hospital in Southeast Tennessee, it is vital that *Erlanger Health System* enhance its facilities to provide the best and most accessible treatment services available for the communities we serve. As an academic medical center affiliated with the University of Tennessee College of Medicine, which is co-located on the *Erlanger Medical Center* campus, *EHS* also seeks to provide appropriate facilities so as to enhance

the training and education of medical residents and fellows as well as other health professionals. Erlanger Health System is planning for tomorrow with regard to behavioral health services for the regional service area, ensuring that the needs of the uninsured and/or low income population are being met.

B. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

Response

A number of alternatives were considered and deemed not to be feasible. These alternatives included locating the proposed project at *Erlanger North Hospital* where a twelve (12) bed Geriatric-Psychiatric unit is already located, however, this was not feasible due to the topography of the site and the inability to accommodate the proposed plan in a functionally efficient manner. Also, cost was anticipated to be higher given the need for extensive site improvements. We next evaluated the *Erlanger Medical Center* campus, however, available land on the main campus is expected to be utilized for construction of a new/replacement children's hospital and for a children's ambulatory care building, leaving little to no space for the new behavioral health hospital.

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(III.) *CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE*

1. List all health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

Response

The most significant relationship between this proposal and the existing healthcare system is that it will be part of an existing health system and enhance *Erlanger Health System's* ability to integrate its services within the regional service area as the safety net provider, trauma center and region's only academic medical center.

By providing these services regardless of a patient's ability to pay, the regional healthcare delivery system is

positively impacted by the services envisioned in the instant application.

The applicant will have transfer arrangements with the following hospitals which are owned by *Erlanger Health System*.

-- Erlanger Medical Center
-- Erlanger North Hospital
-- T. C. Thompson Children's Hospital
-- Erlanger Bledsoe Hospital

Further, Erlanger currently has patient transfer agreements in place with more than 90 hospitals and other providers in the four (4) state area. These providers refer patients to *Erlanger* because of the depth and breadth of its programs and services. It is anticipated that *Erlanger Behavioral Health* will have transfer arrangements for behavioral health services with a majority of these providers. A copy of the list of transfer agreements is attached to this CON application.

2. Describe the positive and / or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

Response

The effects of this proposal will be positive for the healthcare system because it will deliver the most appropriate level of care for those who are in need of service regardless of ability to pay, and will also distribute needed services across the service area to foster improved patient access. By providing this behavioral health service, the regional healthcare delivery system is positively impacted by serving as the "safety net" for those who are otherwise in need of these necessary services.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for

the project. This can be reported using FTE's for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the *Tennessee Dept. Of Labor & Workforce Development* and/or other documented sources.

Response

Clinical staffing for *Erlanger Behavioral Health* is anticipated to be as follows:

Erlanger Bevioral Health -- FTE's By Position Type

	== FTE's == Year 2
CEO	1.0
CFO	1.0
COO	1.0
Admin Assistant	3.2
Billing	2.4
Accounting	1.4
Marketing	1.2
MD	1.6
DON	1.0
Nurse	11.3
Nurse Assistant	31.9
Social Worker	12.0
Other	31.9
Total >>>>	100.9

Appropriate salary comparison data is below.

Position	EHS Avg.	Market Mid-Point
Admin. Assistant	$ 18.03	$ 17.84
Pt. Billing	$ 16.38	$ 16.01
Accounting	$ 29.98	$ 31.93
Marketing Mgr.	$ 53.88	$ 46.21
Psychiatrist	$ 103.45	$ 102.00
Psychiatric RN	-	$ 32.75
Psych. Nurse Asst	-	$ 14.10
Social Worker	$ 27.60	$ 23.09

NOTES
(1) This information is derived from the internal records of *Erlanger Health System*. EHS does not have data for Psychiatric RN and Nurse Assistant.
(2) The market mid-point is derived from the 2015 Mercer Group Salary Survey.

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Dept. Of Health, the Dept. Of Mental Health & Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

Response

The human resources required will be approached with a proactive recruitment action plan. Historically, *Erlanger* has met staffing requirements by utilizing a variety of methods. Thus, our approach to fulfill the staffing plan for the *Erlanger Behavioral Health* will consist of a proactive plan of marketing, screening, hiring, and training.

The Human Resources Department at *Erlanger* will work closely with managers in the transition. The specifics will be based on the needs of the organization and aligned with the strategic needs of the new behavioral health servie. *Erlanger* has actively been involved in the *WorkForce* Development movement on several different levels within the Chattanooga area and statewide. Current vacancy rates are below state and national averages.

Erlanger Health System participates with numerous schools that provide advanced training in the areas of nursing and allied health. Therefore, *Erlanger* expects no difficulty in recruitment of required staff given it's role as an academic medical center and it's affiliations with colleges and universities offering allied health and related training programs.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission

privileges, quality assurance policies and programs, utilization review *policies and programs, record keeping, and staff education.*

Response

The Applicant has reviewed and intends to comply with all licensing and certification requirements imposed by applicable statutes and regulations.

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Response

Erlanger Health System, as the region's only academic medical center, has established strong long term relationships with the region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory, pharmacy and surgery technology, to name a few. It is also expected that *Erlanger Behavioral Health* will do so as well.

A number of regional universities offer Bachelor degree programs in nursing and physical therapy. *Erlanger* works closely with the University of Tennessee at Chattanooga to assist nurses transitioning from RN to BSN. Erlanger provides a teaching environment for staff as well with various on-the-job training opportunities (ex: CT for Radiologic Technologist, Certification for LPNs). Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine, Diagnostic Ultrasonography, etc. *Erlanger Health System* participates with numerous schools that provide advanced training in the areas of nursing and allied health.

Erlanger has established strong long term relationships with the region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory care and pharmacy, to name a few. A number of

regional universities offer Bachelor degree programs in nursing and physical therapy. Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine and Diagnostic Ultrasonography.

The *University of Tennessee - College of Medicine* is co-located at *Erlanger* and includes training of senior medical students on clinical rotation as well as graduate medical education for training of residents and advanced fellowships in various medical specialties, including surgical specialties, as outlined below.

Residency Programs
- Emergency Medicine
- Family Medicine
- Internal Medicine
- Obstetrics & Gynecology
- Orthopedic Surgery
- Pediatrics
- Plastic Surgery
- Surgery
- Urology
- Transitional Year

Fellowship Programs
- Orthopedic Trauma Surgery
- Surgical Critical Care
- Vascular Surgery
- Colon & Rectal Surgery
- Emergency Medicine
- Neuro-Interventional Surgery
- Ultrasound
- Cardiovascular Disease
- Gastroenterology (under development)
- Radiology (under development)
- Neurology (under development)

It should be noted that *Erlanger Health System* is currently in discussions with it's academic partner, the University of Tennessee - College of Medicine, to explore the possibility of a graduate medical education and training residency program in Psychiatry.

Erlanger Health System also participates with numerous schools that provide advanced training in the areas of nursing and allied health.

7. (a) **Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Dept. Of Health, the Dept. Of Mental Health & Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.**

Response

The Applicant has reviewed and intends to comply with all licensing and certification requirements imposed by applicable statutes and regulations.

(b) **Provide the name of the entity from which the applicant has received or will receive licensure, certification, and / or accreditation.**

Licensure: State of Tennessee, Dept. of Mental Health & Substance Abuse

Accreditation: Joint Commission on Accreditation of Healthcare Organizations

If an existing institution, please describe the Current standing with any licensing, certifying, or accrediting agency or commission. Provide a copy of the current license of the facility.

Response

Erlanger Behavioral Health will continuously strive to comply with applicable regulations and make needed changes where deficiencies may arise to ensure full compliance with applicable standards of care and licensure requirements.

(c) **For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an**

approved plan of correction.

Response

*** Not Applicable. ***

8. **Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5 % ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.**

Response

This criterion is not applicable because *Erlanger Health System* operates as the Chattanooga-Hamilton County Hospital Authority, which is a governmental unit and a statutory entity under the State of Tennessee. As such, it is not possible for there to be any "owners", per se, except for the people of Hamilton County, Tennessee, and the State of Tennessee.

9. **Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5 % ownership interest in the project.**

Response

This criterion is not applicable because *Erlanger Health System* operates as the Chattanooga-Hamilton County Hospital Authority, which is a governmental unit and a statutory entity under the State of Tennessee. As such, it is not possible for there to be any "owners", per se, except for the people of Hamilton County, Tennessee, and the State of Tennessee.

10. **If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services And Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed,**

and other data as required.

Response

Applicant will provide the *Health Services And Development Agency* with appropriate information in consideration of this CON application.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of publication of the letter of intent.

Attached is a copy of the *Letter Of Intent* which was filed with the *Tennessee Health Services & Development Agency* on March 10, 2016. The original publication affidavit is also attached to this CON application.

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for cause shown. Subsequent to granting a Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

   Response

   The *Project Completion Forecast Chart* has been completed and appears on the following page.

2. **If the response to the preceding question indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph, please state below any request for an extended schedule and document the "good cause" for such an extension.**

   Response

   *** Not Applicable. ***

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609(c): June 22, 2016

Assuming the CON approval becomes the final Agency action on that date; indicate the number of days from the above agency decision date to each phase of the completion forecast.

PHASE		Days Required	Anticipated Date (MONTH / YEAR)
1.	Architectural and engineering contract signed.	1	08/2016
2.	Construction documents approved by the *Tennessee Dept. Of Health.*	210	03/2017
3.	Construction contract signed.	1	03/2017
4.	Building permit secured.	15	04/2017
5.	Site preparation completed.	60	06/2017
6.	Building construction commenced.	1	06/2017
7.	Construction 40 % complete.	120	10/2017
8.	Construction 80 % complete.	120	02/2018
9.	Construction 100 % complete (approved for occupancy.	60	04/2018
10.	*Issuance of license.	30	05/2018
11.	*Initiation of service.	1	06/2018
12.	Final Architectural Certification Of Payment.	1	06/2018
13.	Final Project Report Form (HF0055).	1	06/2018

(*) For projects that do NOT involve construction or renovation, please complete items 10 and 11 only.

NOTE – If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

A F F I D A V I T

STATE OF TENNESSEE

COUNTY OF HAMILTON

Joseph M. Winick, being first duly sworn, says that he / she is the applicant named in this application or his / her / it's lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Agency Rules, and T.C.A. § 68-11-1601, *et seq*, and that the responses to this application or any other questions deemed appropriate by the Tennessee Health Services & Development Agency are true and complete.

SIGNATURE

SWORN to and subscribed before me this 11 of March (Month), 2016 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

NOTARY PUBLIC

ROBIN S. DEBOLT
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

My commission expires October 10, 2016 (Month / Day) 20____.

TABLE OF ATTACHMENTS

Proof Of Publication

HSDA - Letter Of Intent
HSDA - Publication Of Intent
Affidavit Of Publication

Description	Section / Item
Secretary Of State Acknowledgement	A-4
Articles Of Organization	A-4
Letter Of Agreement - Real Estate Option	A-6
Option To Purchase Real Estate	A-6
Square Footage & Cost Per Square Foot Chart	B-II-A
Erlanger Behavioral Health - Site Plan	B-III-A
Erlanger Behavioral Health - Floor Plans	B-IV
Service Area	C-I-3
Architect Letter - Construction Cost	C-II-1
Funding - Acadia CFO Letter	C-II-2
Other Expenses - Historical Data Chart	C-II-4
Other Expenses - Projected Data Chart	C-II-4
Erlanger Interim Financial Statements	C-II-10
Erlanger Audited Financial Statements	C-II-10
List Of Erlanger Patient Transfer Agreements	C-III-1

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Chattanooga Times Free Press
TIMESFREEPRESS.COM
VOL. 147 › NO. 87 › $1.00
THURSDAY
MARCH 10, 2016

LEGAL NOTICES

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et. seq., and the Rules of the Health Services & Development Agency, that Erlanger Behavioral Health, LLC, with an ownership type of for profit, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to construct a new psychiatric hospital with a total complement of eighty-eight (88) inpatient beds, to include services for inpatients, outpatients and substance abuse. Further, we are requesting approval to transfer twelve (12) licensed Geriatric - Psychiatric beds currently at Erlanger North Hospital to the new Erlanger Behavioral Health campus. This will create a net addition of seventy-six (76) new inpatient psychiatric beds. If approved, the number of hospital beds at Erlanger North Hospital will decrease from fifty seven (57) beds to forty-five (45) beds upon completion of the project. No other health care services will be initiated or discontinued.

The facility and equipment will be located at Erlanger Behavioral Health, at a site located at the intersection of North Holtzclaw Avenue & Citico Avenue, Chattanooga, Hamilton County, Tennessee, 37404. The total project cost is estimated to be $ 25,112,600.00.

The anticipated date of filing the application is March 15, 2016.

The contact person for this project is Joseph M. Winick, Sr. Vice President, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee, 37403, and by phone at (423) 778-7274.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Pursuant to T.C.A. § 68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate Of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

103 2788719
ERLANGER STRATEGIC

STATE OF TENNESSEE
HAMILTON COUNTY

Before me personally appeared Jim Stevens who being duly sworn, that he is the Legal Sales Representative of the "CHATTANOOGA TIMES FREE PRESS" and that the Legal Ad of which the attached is a true copy, has been published in the above said Newspaper and on the website on the following dates, to-wit:

March 10, 2016

And that there is due or has been paid the "CHATTANOOGA TIMES FREE PRESS" for publication of such notice the sum of $223.71 Dollars. (Includes $10.00 Affidavit Charge).

Jim Stevens

Sworn to and subscribed before me, this 10th day of March, 2016.

Amanda Crawford

My Commission Expires 10/17/2018

AMANDA CRAWFORD
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY
MY COMMISSION EXPIRES OCTOBER 17, 2018

Chattanooga Times Free Press

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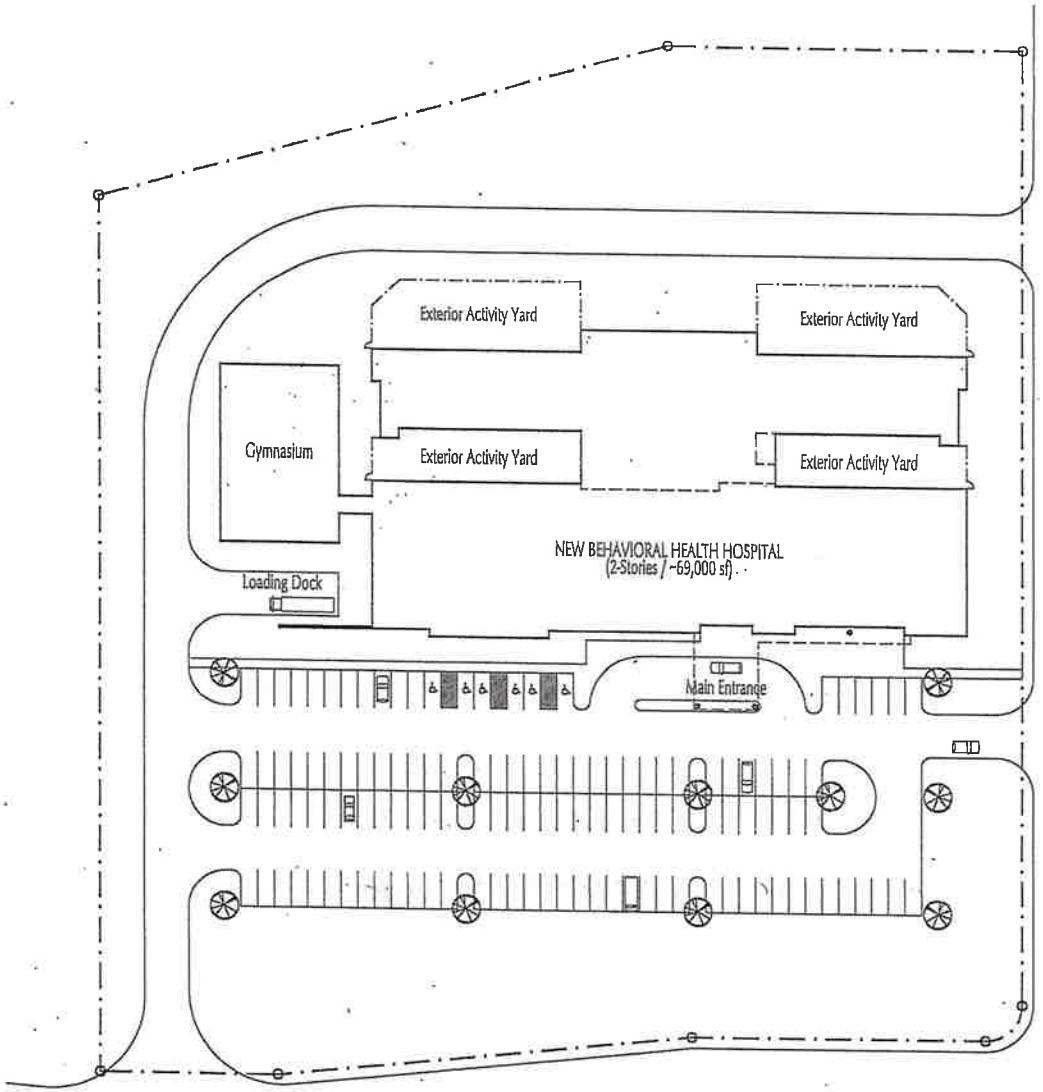
SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost / SF		
					Renovated	New	Total	Renovated	New	Total
Administration						3,850	3,850		$ 271.30	$ 1,044,505
Building Support						1,770	1,770		$ 271.30	$ 480,201
Dietary						4,510	4,510		$ 271.30	$ 1,223,563
Education / Activity Therapy						5,360	5,360		$ 271.30	$ 1,454,168
Inpatient Nursing Units						23,580	23,580		$ 271.30	$ 6,397,254
Outpatient Therapy						2,775	2,775		$ 271.30	$ 752,858
Pharmacy						300	300		$ 271.30	$ 81,390
Public Spaces						880	880		$ 271.30	$ 238,744
B. Unit/Department GSF Sub-Total						43,025	43,025		$ 271.30	$ 11,672,683
C. Mechanical / Electrical GSF						990	990		$ 271.30	$ 268,587
D. Circulation / Structure GSF						24,985	24,985		$ 271.31	$ 6,778,730
E. Total GSF						69,000	69,000		$ 271.30	$ 18,720,000

Description	Section / Item
Erlanger Behavioral Health - Site Plan	B-III-A



107

Approximate Size Of Sit

6.02 Acres

March 28, 2016
11:49 am

SUPPLEMENTAL #1

AREA SUMMARY	
New Building Area - First Floor	50,900 sf
New Building Area - Second Floor	18,100 sf
TOTAL NEW BUILDING AREA	69,000 sf

NORTH

GRAPHIC SCALE

0' 50' 100' 200'

CONCEPTUAL SITE PLAN
SEE GRAPHIC SCALE

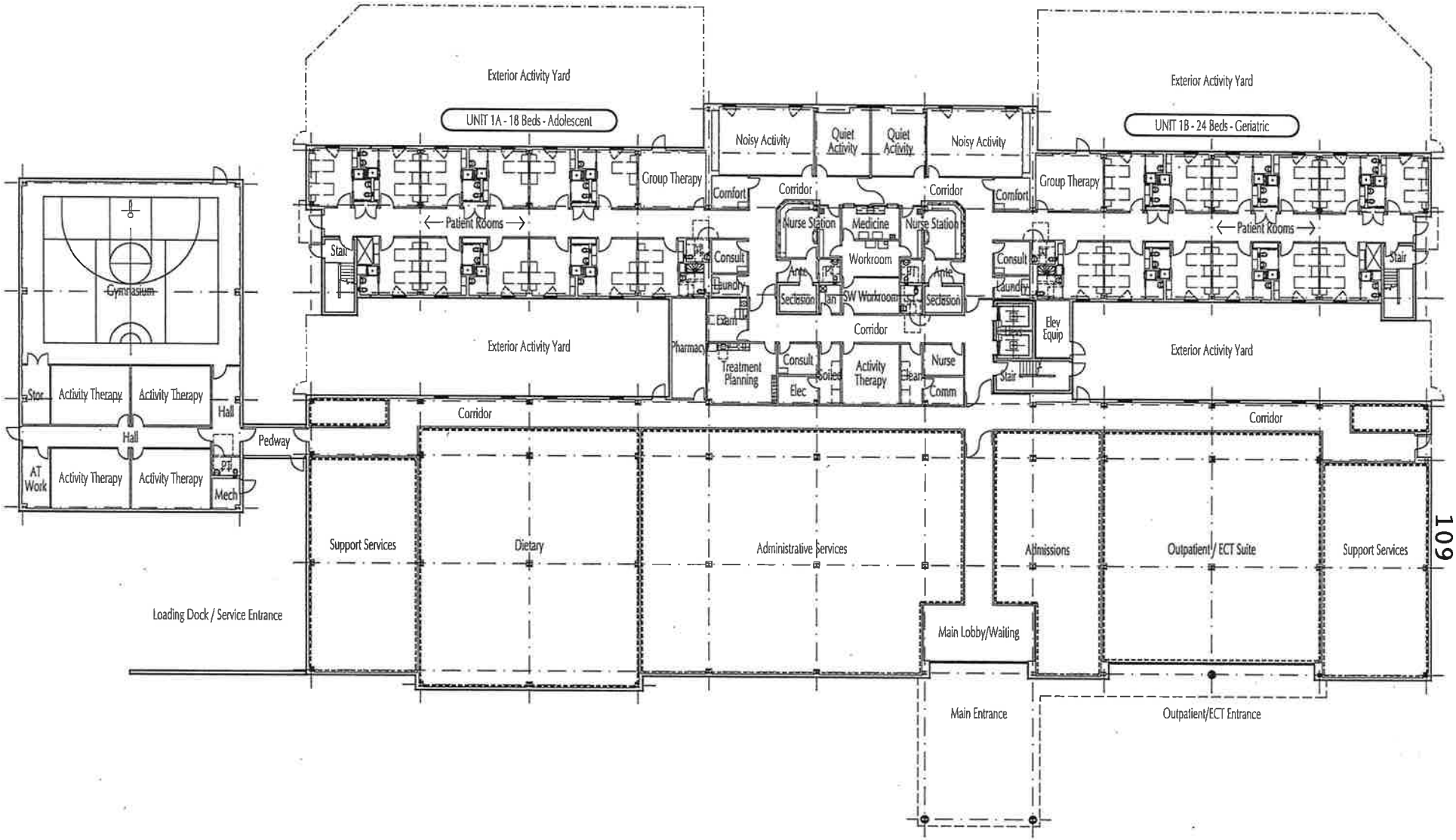
NEW BEHAVIORAL HEALTH HOSPITAL
ERLANGER BEHAVIORAL HEALTH, LLC
CHATTANOOGA, TENNESSEE

C001-00

AHC1504 | 14 MARCH 2016

STENGEL-HILL ARCHITECTURE
413 WEST MAIN STREET LOUISVILLE, KENTUCKY 40202 502.893.1875 502.893.1876 fax

Description	Section / Item
Erlanger Behavioral Health – Floor Plans	B-IV



AREA SUMMARY	
New Building Area - First Floor	50,900 sf
New Building Area - Second Floor	18,100 sf
TOTAL NEW BUILDING AREA	69,000 sf

NORTH

GRAPHIC SCALE

0' 20' 40' 80'

CONCEPTUAL FIRST FLOOR PLAN

SEE GRAPHIC SCALE

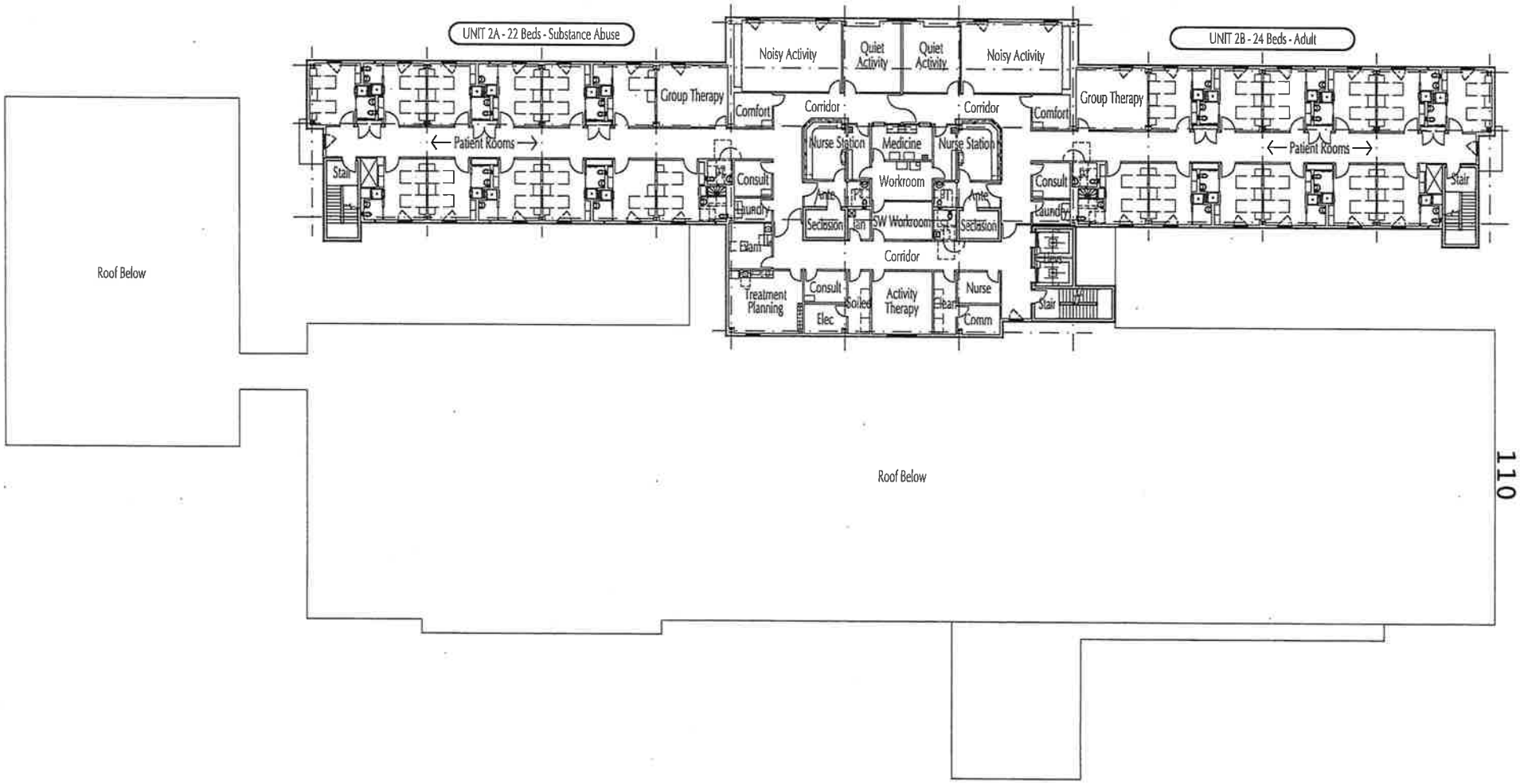
NEW BEHAVIORAL HEALTH HOSPITAL
ERLANGER BEHAVIORAL HEALTH, LLC
CHATTANOOGA, TENNESSEE

CO01-01

AHC1504

14 MARCH 2016

STENGEL-HILL ARCHITECTURE
613 WEST MAIN STREET LOUISVILLE, KENTUCKY 40202 502.893.1875 502.893.1876 fax



AREA SUMMARY	
New Building Area - First Floor	50,900 sf
New Building Area - Second Floor	18,100 sf
TOTAL NEW BUILDING AREA	69,000 sf

NORTH

GRAPHIC SCALE

0' 20' 40' 80'

CONCEPTUAL SECOND FLOOR PLAN

SEE GRAPHIC SCALE

NEW BEHAVIORAL HEALTH HOSPITAL
ERLANGER BEHAVIORAL HEALTH, LLC
CHATTANOOGA, TENNESSEE

CO01-02

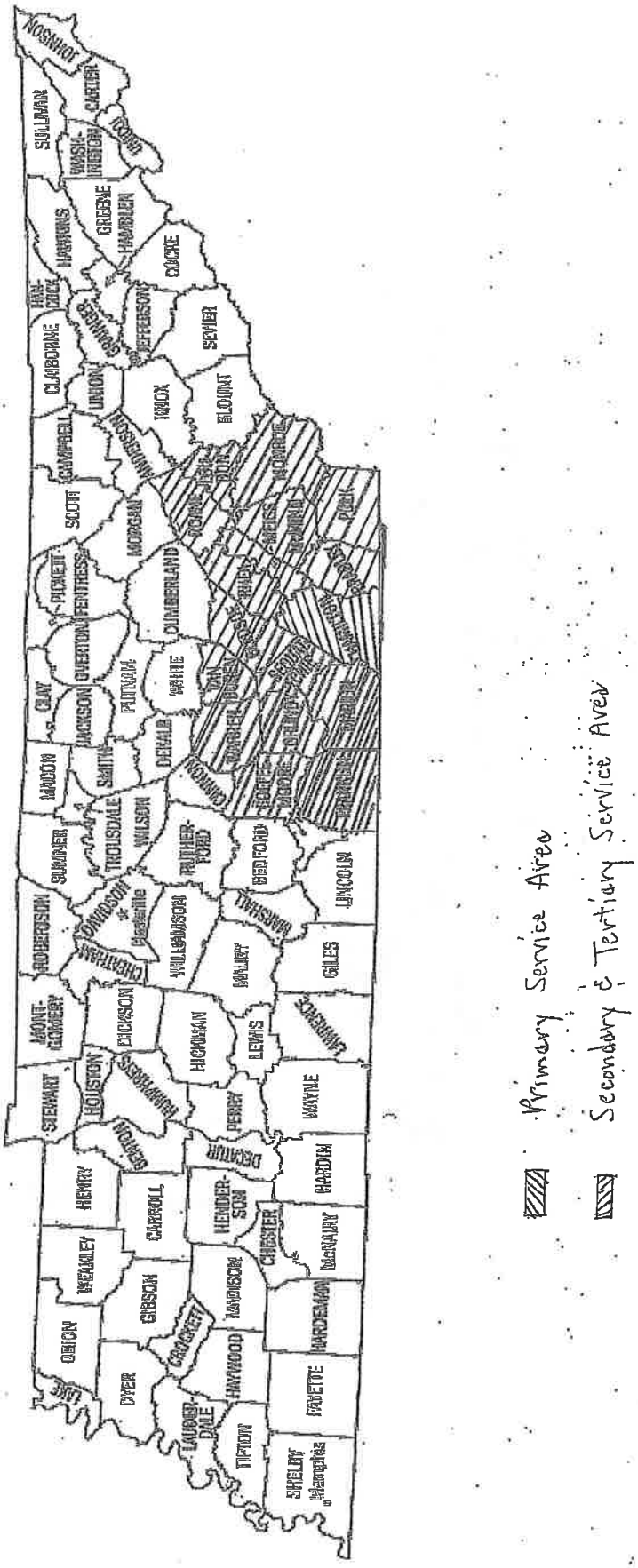
AHC1504

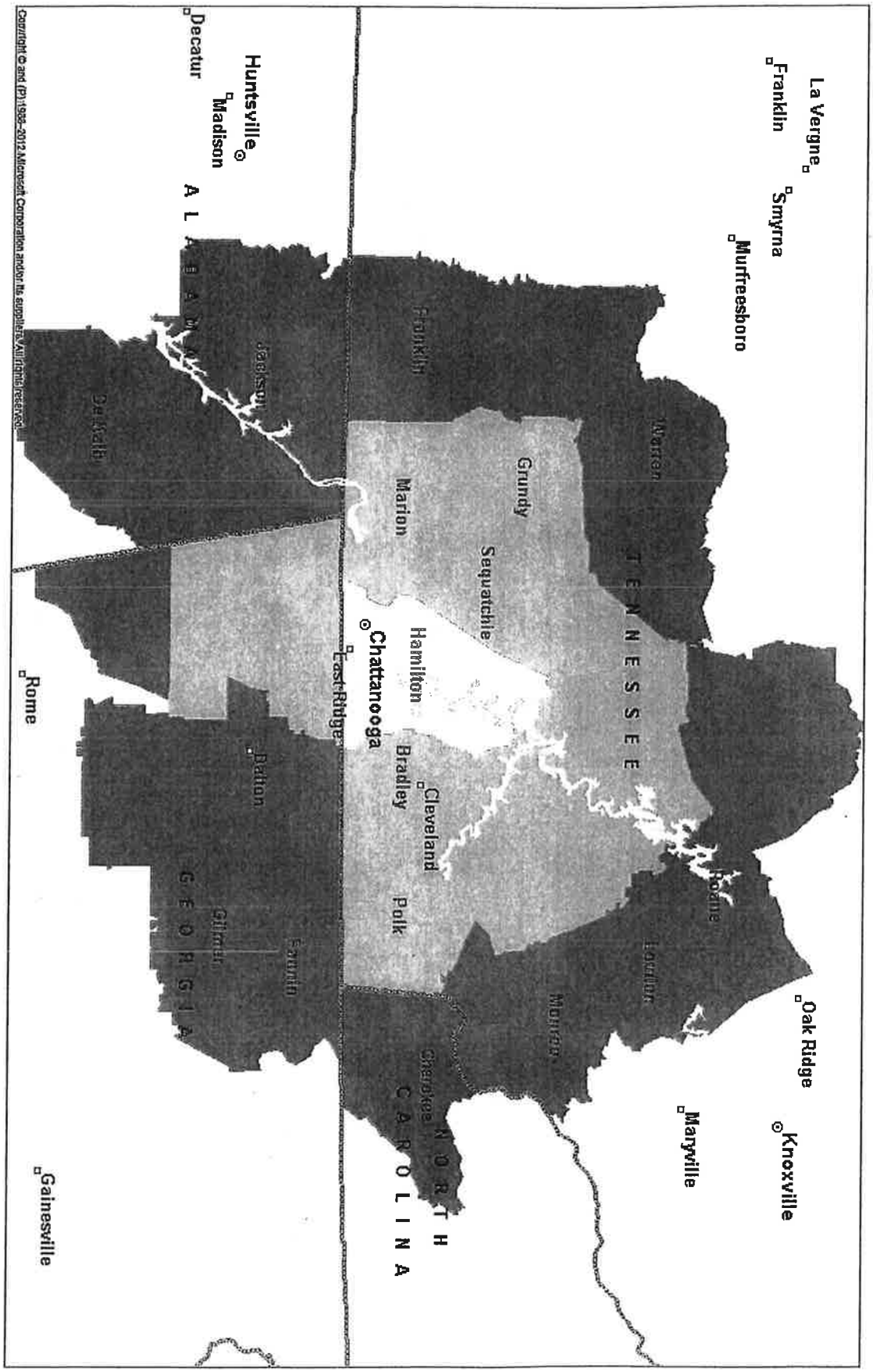
14 MARCH 2016

STENGEL-HILL ARCHITECTURE
613 WEST MAIN STREET LOUISVILLE, KENTUCKY 40202 502.893.1875 502.893.1876 fax

Description	Section / Item
Service Area	C-I-3

County	State	Service Area
Hamilton	TN	PSA
Bledsoe	TN	SSA
Bradley	TN	SSA
Grundy	TN	SSA
Marion	TN	SSA
McMinn	TN	SSA
Meigs	TN	SSA
Polk	TN	SSA
Rhea	TN	SSA
Sequatchie	TN	SSA
Catoosa	GA	SSA
Dade	GA	SSA
Walker	GA	SSA
Dekalb	AL	TSA
Jackson	AL	TSA
Chattooga	GA	TSA
Fannin	GA	TSA
Gilmer	GA	TSA
Gordon	GA	TSA
Murray	GA	TSA
Whitfield	GA	TSA
Cherokee	NC	TSA
Coffee	TN	TSA
Cumberland	TN	TSA
Franklin	TN	TSA
Loudon	TN	TSA
Monroe	TN	TSA
Roane	TN	TSA
Van Buren	TN	TSA
Warren	TN	TSA


Primary Service Area
Secondary & Tertiary Service Area


La Vergne
Franklin
Smyrna
Murfreesboro
Huntsville
Madison
Decatur
Oak Ridge
Knoxville
Maryville
Rome
Gainesville
Chattanooga
Cleveland
Dalton
East Ridge
Franklin
Warren
Grundy
Sequatchie
Marion
Hamilton
Bradley
Polk
Rhea
Loudon
Monroe
Jackson
DeKalb
Fannin
Gilmer
TENNESSEE
NORTH CAROLINA
GEORGIA
ALABAMA
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Description	Section / Item
Architect Letter – Construction Cost	C-II-1

STENGEL-HILL ARCHITECTURE

Joseph M. Winick, FACHE
Senior Vice President
Planning, Analytics & Business Development
Erlanger Health System
975 East 3rd Street
Chattanooga, TN 37403

RE: Attestation of Construction Cost
New Behavioral Health Hospital
Erlanger Behavioral Health, LLC
Chattanooga, Tennessee

14 March 2016

SHA.AHC1504

Joe,

Per recent conversations with you regarding a Certificate of Need Submission for a New Behavioral Health Hospital for Erlanger Behavioral Health, LLC in Chattanooga, Tennessee, I have prepared the following supporting documentation for your review.

I have reviewed the construction cost estimate provided by Erlanger Behavioral Health, LLC in the CON Submission for this Project. Based on my experience and knowledge of the current health care market, it is my opinion that the projected construction cost of $18,720,000 appears to be reasonable for a project of this type and size.

Additionally, please note that the Project will be designed in compliance with all applicable State and Federal Regulations, including the following:

- → Guidelines for the Design and Construction of Health Care Facilities
- → Rules of the Tennessee Department of Health - Board for Licensing Health Care Facilities
- → International Building Code
- → National Electrical Code
- → National Fire Protection Association (NFPA) Codes
- → Americans with Disabilities Act (ADA)

If you have any questions or comments regarding this information, please do not hesitate to contact me at your convenience.

Thank you.

Bradford P. Stengel, AIA
Senior Principal
Stengel Hill Architecture Incorporated
Tennessee Registered Architect No. #000102 523

BRADFORD P. STENGEL
REGISTERED ARCHITECT
AGRICULTURE
COMMERCE
No. 000102 523
STATE OF TENNESSEE

copy: Andy Hanner AHC

613 WEST MAIN STREET LOUISVILLE, KENTUCKY 40202
tel: 502.893.1875 fax: 502.893.1876 www.stengelhill.com

Description	**Section / Item**
Funding - Acadia CFO Letter	C-II-2

ACADIA
HEALTHCARE

April 4, 2016

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Frost Building, Third Floor
161 Rosa Parks Boulevard
Nashville, Tennessee 37203

RE: Financing Commitment
Erlanger Behavioral Health, LLC
Hamilton County

Dear Mrs. Hill:

Erlanger Behavioral Health, LLC, a proposed joint venture of Erlanger Health System and Acadia Healthcare, is applying for a Certificate of Need to establish a new psychiatric and substance abuse hospital Hamilton County.

This letter is to confirm that Acadia Healthcare will provide the approximately $25,112,600 in funding required to construct the hospital and implement that project. Acadia intends to finance these costs with borrowings from its existing $300 million revolving credit facility.

Acadia's most recent audited financial statements are provided in the application. Please let me know if you have any questions.

Sincerely,

David Duckworth
CFO

Supplemental #1
-COPY-

Erlanger Behavioral Health, LLC.

CN1603-012

SUPPLEMENTAL INFORMATION

Erlanger Behavioral Health, LLC

Application To Initiate Psychiatric Services At The Intersection Of North Holtzclaw Avenue And Citico Avenue, In Chattanooga, Tennessee, With Establishment Of An Eighty-Eight (88) Bed Inpatient Hospital By The Addition Of Seventy-Six (76) Psychiatric Beds And The Transfer Of Twelve (12) Geriatric-Psychiatric Beds From *Erlanger North Hospital*

Application Number CN1603-012

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Supplemental Responses To Questions Of The Tennessee Health Services & Development Agency

1.) Section A, Applicant Profile, Item 6.

Please provide documentation, e.g., copy of a deed, etc. that Medical Development Partners, LLC currently owns the property of the site for the proposed project.

The Option to Purchase Agreement is noted. However, please clarify how the applicant can secure the property site while 100% of the proposed project will be funded by an unrelated party not included in the Option to Purchase Agreement. In addition, there is no address listed on the agreement. Please revise.

Response

A *Quit Claim Deed* dated December 31, 2007, filed in the Register's Office of Hamilton County, Tennessee, on April 4, 2008, is attached to this supplemental information.

A *Letter of Agreement* between *Erlanger Health System* and *Acadia Healthcare* is attached to this supplemental information. The agreement specifies the responsibilities of each party in the joint venture and satisfactorily outlines the two (2) stage process which will be followed in development of this project, ultimately leading to *Acadia* fully funding the project.

Attached to the CON application was a copy of the *Option To Purchase Real Estate*. Along with this *Option*, a copy of the *Letter of Agreement* between *Erlanger* and the *Purchaser* of the real estate, *Hickory Land Co., LLC*, in which the *Purchaser* agrees to "irrevocably assign to *Erlanger* or to a subsidiary or an affiliate of *Erlanger* (including a joint venture) at *Erlanger's* discretion, all of Purchaser's rights, benefits, title, interests, liabilities and obligations" under the *Option To Purchase*. As such, *Erlanger* does control the site.

The *Option To Purchase* does specify an address in the first paragraph, that is 804 N. Holtzclaw Avenue. However, there are two (2) parcels stipulated in the first

paragraph, those are tax parcels 146C-A022 and 146C-A023. Since the proposed site for the new hospital straddles both parcels, it is as yet undetermined which parcel will be the actual mailing address of the facility.

2.) Section A, Bed Complement Data, Item 9.

It is noted 12 geriatric psychiatric beds will transfer from Erlanger North. Please provide a bed complement data chart for Erlanger North Hospital.

Please clarify if the proposed 88 bed psychiatric hospital will operate under the license of Erlanger Hospital. If so, how will a joint venture with Acadia impact being licensed under Erlanger Health System?

Response

Erlanger Behavioral Health will be licensed separately from *Erlanger Medical Center*.

A bed complement chart for *Erlanger North Hospital* is below.

Bed Type	Erlanger North
Medical	27
Surgical	14
Long-Term Care Hospital	
Obstetrical	
ICU / CCU	4
Neonatal ICU	
Pediatric	
Adult Psychiatric	
Geriatric Psychiatric	12
Child / Adolescent Psychiatric	
Rehabilitation	
Nursing Facility (non-Medicaid Certified)	
Nursing Facility Level 1 (Medicaid only)	
Nursing Facility Level 2 (Medicare only)	
Nursing Facility Level 2 (dually certified – Medicaid / Medicare)	
ICF / MR	
Adult Chemical Dependency	
Child & Adolescent Chemical Dependency	
Swing Beds	
Mental Health Residential Treatment	
Residential Hospice	
TOTAL	57

3.) Section A, Applicant Profile, Item 13.

It is noted the applicant and one other provider are enrolled in Blue Network S, and Erlanger is the only provider enrolled in Network E. What is the name of the other provider enrolled in Network S? Please provide a source for enrollment numbers provided for both networks.

Please define Blue Network E and Blue Network S and provide an overview of behavioral and substance abuse benefits covered under each plan.

What is Blue Network P?

The applicant references behavioral health organizations (BHOs). Please name the BHOs the applicant is referencing.

Response

The other provider in Chattanooga which is enrolled in *Blue Network S* is *Parkridge Health System*. The source of enrollment data for *Blue Network E* and *Blue Network S*, was information provided by *Blue Cross / Blue Shield* leadership.

Blue Network E is described on the *Blue Cross / Blue Shield of Tennessee* website as the "*Essential*" network. *Blue Network S* is described as the "*Select*" network. *Blue Network P* is described as the "*Preferred*" network.

Generally, behavioral health benefits are a covered service through the *Blue* networks when they are received from a contracted provider or a non-contracted provider depending on the member's health care benefit plan. Program services are covered when received in a licensed behavioral health facility program, or unit for mental health disorders or substance use disorders and when prior authorization is given by the member's health care benefit plan. Program services include acute care, residential care, partial hospitalization, intensive outpatient programs, and inpatient and outpatient electroconvulsive therapy (ECT).

As part of the *HSDA* form pertaining to Section A, Item 13, reference is made to *Behavioral Health Orgnization's* which are part of the TennCare program. Applicant's

operating the following:

- An Adult Inpatient Chemical Dependency Unit
- An Adult Psychiatric Unit
- An Child and Adolescent Inpatient Psychiatric Unit
- A Gero-Inpatient Psychiatric Unit

The applicant notes there are a total of 252 licensed inpatient beds in the proposed service area. Does this number include licensed beds at Moccasin Bend Mental Health Institute (MBMHI)? If not, what is the number of licensed beds with MBHMI included?

It is noted Acadia Healthcare will fund the $25,112,600 proposed project. If so, please provide the documentation that obligates Acadia Healthcare to fund the proposed project.

Response

Erlanger has been in discussion with *Acadia* but only recently crafted and agreed to a *Letter of Intent*. *Erlanger* was well aware of the need for additional behavioral health services and has been working to address this need in an effective manner. Approval was received from the *US Health Resources & Services Administration* to initiate behavioral health at our FQHC sites approximately three years ago. We also added a psychiatry division with psychiatrist and placed LCSW's in our Emergency Department to address the large volume of patients with co-existing medical and behavioral health conditions. With a large volume of patients currently served, we believe the timing is right to move forward with the filing of the *Certificate of Need*, now that the *Letter of Intent* has been completed. We expect to be working to develop the joint venture concurrently with the review of the *Certificate of Need*.

A copy of the *Letter of Agreement* between *Erlanger Health System* and *Acadia Healthcare* is attached to this supplemental information. The agreement specifies a two (2) stage process that will be followed for development of this project.

There will not be a future management company, the CON application specifies that management officers will be hired by *Erlanger Behavioral Health*. There will not be

"management fees", per se, as understood in the traditional sense of that term because the officers will be hired directly by *Erlanger Behavioral Health*. However, there will be "fees" from *Acadia* for support services to *Erlanger Behavioral Health*, equal to 2% of net revenue as outlined in paragraph eight (8) of the agreement. The 2% fees were not identified and were inadvertently included in *Other Expenses* on the *Projected Data Chart*. For this reason we have included a replacement page 57 for the *Projected Data Chart*.

As specified in the *Letter of Agreement*, the second stage of project development will include determination of specific details after the CON is approved. It is anticipated that the time period necessary to conclude these detail discussions will be 60 to 90 days, or less.

The involvement of *Acadia* in development and filing the CON application is to provide the architectural and engineering support, as well as necessary information pertaining to operation of a psychiatric hospital, such as the financial information. A majority of the preliminary development work has been conducted by *Erlanger*, with collaboration by Acadia, such as site selection, etc.

As of this point in time, it is unknown precisely what *Acadia's* ownership percentage will be. *Erlanger* and *Acadia* will work with an independent valuation consultant to determine proportional ownership interests by the respective parties.

Erlanger Behavioral Health will serve the defined service area as a "safety net provider" as that term is generally understood, this is outlined in the *Letter of Agreement* between *Erlanger* and *Acadia*. While the *Dept. Of Mental Health* does not have such a designation as does the *Bureau of TennCare*, applicant will operate in such a manner which "recognizes and promotes *Erlanger's* objective of providing charity care". (Please see paragraph 7 of the *Letter Of Agreement*.)

Erlanger Behavioral Health will be classified and licensed as an Institution for Mental Disease (IMD) licensed by the *Dept. of Mental Health*, not as a department of *Erlanger Medical Center*.

As a newly established provider, *Erlanger Behavioral Health* will draw upon the experience of both *Erlanger* and *Acadia* in operating psychiatric programs. *Erlanger North Hospital* currently operates an inpatient geriatric psychiatric program, to be relocated to the new hospital, and *Acadia* has experience in the operation of adult psychiatric units, child and adolescent inpatient unit and adult chemical dependency programs with 585 facilities worldwide. *Erlanger* also has a psychiatric division with employed psychiatrist and provides service to inpatients as well as children in the emergency department and its *Federally Qualified Health Centers*.

The analysis of current bed supply in the service area presented in the CON application does not include *Moccasin Bend Mental Health Institute*. The number of beds at *MBMHI* is 150. It should be noted that *MBMHI* service area is the 52 counties in East Tennessee extending as far north as the Virginia and Kentucky state lines; the service area for Erlanger Behavioral Health is only 18 counties in Southeast Tennessee. The beds at *MBMHI* are utilized for patients with long term mental health issues, not those generally served in community based programs. Further, it is noted that in the *Agency's* staff report for the *Crestwyn Behavioral Health* application (no. CN1310-040), it was stated that "traditionally, the State operated mental health institutions care for long term mental health patients". Also, that "the applicant did not assess the impact the proposal would have on either of the State facilities".1

As to *Acadia's* obligaton to fund the project, please see paragraph 3(c) of the *Letter of Agreement* which specifies that *Acadia* will pay for design & construction, etc.

5.) Section B, Project Description, Item II.A.

Please clarify if the eighteen adolescent and child unit will be coed. If so, how and when will females and males be segregated?

Please clarify if all the proposed psychiatric units will be locked.

---

1 See *Application Summary* by *HSDA* staff dated October 13, 2013, p. 4, Item C-3, *Crestwyn Behavioral Health*, CON No. CN1310-040.

What are the proposed age ranges for each of the three proposed psychiatric units and adult chemical dependency unit?

Response

The child & adolescent unit of *Erlanger Behavioral Health* will be co-ed. Generally, males will be assigned to rooms on one side of the hallway and females will be assigned to rooms on the other side of the hallway.

Each of the proposed units within the facility will be locked.

The proposed age ranges for the units are as follows.

Unit Description	Age Range
Child / Adolescent	0-17
Adult	18-64
Geriatric	65+
Adult Chemical Dependency	18-64

6.) Section B, Project Description Item III.A.(Plot Plan).

The plot plan is noted. Please provide a revised plot plan that includes the size of site (in acres).

Response

A revised plot plan with the size of the site (in acres) is attached to this supplemental information.

7.) Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services A. Need, 1).

Please include Moccasin Bend Mental Health Institute's licensed beds in the bed calculations on page 33, and in the tables and narrative response on page 34 and submit a replacement page. The Guidelines for Growth does not exclude state Mental Health Institutes in determining psychiatric bed need.

Please reference the data source the applicant used to determine the bed need in the proposed service area.

Response

As requested, *MBMHI* has been added to the inventory of current bed supply for psychiatric services in the defined service area. The data source for population information in this analysis was obtained from *Claritas*, a leading provider of demographic data. Population data was not available on the *Tennessee Dept. of Health* website. The replacement pages (34-36) are attached to this supplemental information.

However, applicant will point out that information on the *MBMHI* website indicates that …

> "*MBMHI* assists patients who are not typically served by the private service sector and have no other inpatient treatment resources available to them."

Thus, *MBMHI* itself categorically states that it does serve those who are covered by the private service sector.

It should be noted that *MBMHI* service area is the 52 counties in East Tennessee extending as far north as the Virginia and Kentucky state lines; the service area for *Erlanger Behavioral Health* is only 18 counties in Southeast Tennessee. The beds at *MBMHI* are utilized for patients with long term mental health issues, not those generally served in community based programs. Further, it is noted that in the *Agency's* staff report for the *Crestwyn Behavioral Health* application (no. CN1310-040), it was stated that "traditionally, the State operated mental health institutions care for long term mental health patients". Also, that "the applicant did not assess the impact the proposal would have on either of the State facilities".

8.) Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services A. Need, 3).

What is the calculated bed need for child/adolescents ages 0-17? Please describe the age range of patients served by the proposed child adolescent psychiatric program.

Response

The need information presented in the CON application indicates that there is an over supply of five (5) child/adolescent psychiatric beds in the defined service area for the age group 0-17. However, it should be noted that *Parkridge Valley Hospital for Children & Adolescents*, had a utilization rate of 79.6%, or 80.0%, for CY 2014.[2] From a health planning perspective, the threshold for consideration of additional beds in a service category is traditionally 80.0%.

Erlanger Behavioral Health will serve children and adolescents with emotional and behavioral health problems, of all ages. Individualized care plans will provide a foundation for stabilization for those in crisis or otherwise in need of this service. The professional team will collaborate with outpatient treatment providers and provide patient and family education to ensure those involved with the patient's care understand emotional health issues as well as symptom management. For this age group, family involvement is crucial.

9.) Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services B.1. (Service Area).

Please submit an online request to the Tennessee Department of Health, Division of Health Statistics, requesting patient discharge utilization data (inpatient day or discharge patient days) for the most recent year available by MCD19 (Mental Diseases and Disorders) and MCD 20 (Alcohol/Drug Abuse & Alcohol/Drug-Induced Organic Mental Disorders) by patient origin by facility by county for the proposed service area. Please include the data in a table listing the facility and associated inpatient days or discharge patient days for the age groups 0-17, 18-64, and 65+.

Response

The number of inpatient days by county of patient origin for MDC's 19 and 20, is attached to this supplemental request.

---

2 The calculation for utilization is 86 average daily census divided by 108 psychiatric beds, this information is derived from the *Joint Annual Report* for CY 2014, p. 23.

SUPPLEMENTAL #2
March 28, 2016
11:49 am

10.) Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services) B. 2. Service Area Demographics and Section C. Need. Item 4.A Service Area Demographics.

Please complete the following chart for each county in the proposed service area.

Demographic Data	County #1	County #2	Etc.	Service Area Total	State of TN Total
0-17 Population-2016					
0-17 Population-2020					
0-17 Population % Change					
0-17 Population % of Total Population					

Response

As requested, the table has been completed.

Erlanger Bevioral Health -- 0-17 Age Group Demographics

	0-17 Pop. CY 2016	0-17 Pop. CY 2020	0-17 Pop. % Change	0-17 Pop. % Of Total -2016	0-17 Pop. % Of Total -2020
Hamilton County, TN	76,469	78,962	3.3%	22.2%	22.7%
Bradley County, TN	22,712	22,612	-0.4%	6.6%	6.5%
Marion County, TN	3,533	5,811	64.5%	1.0%	1.7%
Grundy County, TN	2,891	2,758	-4.6%	0.8%	0.8%
Sequatchie County, TN	3,366	3,406	1.2%	1.0%	1.0%
Bledsoe County, TN	2,544	2,437	-4.2%	0.7%	0.7%
Rhea County, TN	8,897	8,952	0.6%	2.6%	2.6%
Meigs County, TN	2,339	2,213	-5.4%	0.7%	0.6%
McMinn County, TN	11,293	11,045	-2.2%	3.3%	3.2%
Polk County, TN	3,493	3,352	-4.0%	1.0%	1.0%
Dade County, GA	3,262	3,118	-4.4%	0.9%	0.9%
Walker County, GA	15,052	14,548	-3.3%	4.4%	4.2%
Catoosa County, GA	15,258	14,909	-2.3%	4.4%	4.3%
DeKalb County, AL	17,601	17,268	-1.9%	5.1%	5.0%
Jackson County, AL	11,213	10,768	-4.0%	3.3%	3.1%
Chatooga County, GA	5,419	5,168	-4.6%	1.6%	1.5%
Fannin County, GA	4,311	4,263	-1.1%	1.3%	1.2%
Gilmer County, GA	5,241	6,048	15.4%	1.5%	1.7%
Gordon County, GA	14,355	14,197	-1.1%	4.2%	4.1%
Murray County, GA	9,911	9,570	-3.4%	2.9%	2.8%
Whitfield County, GA	28,674	29,927	4.4%	8.3%	8.6%
Cherokee County, NC	4,842	4,694	-3.1%	1.4%	1.4%
Coffee County, TN	12,589	12,511	-0.6%	3.7%	3.6%
Cumberland County, TN	10,642	10,820	1.7%	3.1%	3.1%
Franklin County, TN	8,363	8,069	-3.5%	2.4%	2.3%
Loudon County, TN	10,082	10,266	1.8%	2.9%	3.0%
Monroe County, TN	9,834	9,708	-1.3%	2.9%	2.8%
Roane County, TN	10,020	9,351	-6.7%	2.9%	2.7%
Van Buren County, TN	1,026	965	-5.9%	0.3%	0.3%
Warren County, TN	9,483	9,421	-0.7%	2.8%	2.7%
Total >>>>	344,715	347,137	0.7%	100.0%	100.0%

11.) Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services C. 1. Relationship to existing applicable plans (State, City, County, Regional Plans)

Other than the Tennessee Guidelines for Growth, are there other existing applicable plans (city, county, and/or regional) that has a relationship to the proposed project? Please clarify.

Response

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Applicant is not aware of any other "plans" that have a relationship to this proposal. We checked the *Chattanooga-Hamilton County Regional Planning Agency*, the *City of Chattanooga*, and *Hamilton County*. While we were not able to identify any "plans", per se, we have been able to validate certain other pertinent information relating to this project.

For instance, in 2015 the *Hamilton County Health Dept.* published a report titled "*Picture Of Our Health - Hamilton County, Tennessee - 2015 Community Health Profile*". This report presents a "snapshot" of the community's health. The suicide rate is cited as having increased by 27.3% between 2000 and 2015, from a rate of 11.3 per 100,000 to a rate of 14.4.

The *Tennessee Dept. of Mental Health* 2015 Data Book, states that *Tennessee* ranks in the bottom 10 states in the nation, for the following indicators of behavioral health.

- Adults that smoke everyday.
- Adults limited in activity due to physical, mental or emotional problems.
- Adults with mental illness in the past year.
- Youth that used methamphetamine 10 or more times during their lifetime.
- Youth that used prescription drugs without a doctor's prescription.

The *National Institute of Mental Health* reports on it's website that the prevalence of Schizophrenia is 1.1% of the general population, and 60% of those will utilize some form of healthcare service in a year. Therefore, within the defined service area for this *Erlanger Behavioral Health*, a total of 17,285 people have Schizophrenia and 10,371 will utilize healthcare services each year.

These indicators all point to the acute need for *Erlanger Behavioral Health*.

12.) Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services C. 4. Relationship to existing applicable plans (Involuntary Admissions).

Does the applicant expect to accept all involuntary admissions (all ages)? Will the applicant have the expertise and staff to monitor patients who may require one to one observation or may require special treatment?

Please discuss examples of when the applicant could not accept an "Involuntary Admission." In a situation where the applicant could not take an "Involuntary Admission", what protocols would the applicant enact to assure the patient could receive proper treatment?

Response

Generally, applicant will accept all involuntary admissions, to include all ages. However, this policy is subject to bed availability within the facility, the hospital's current staffing and treatment loads, etc. *Erlanger Behavioral Health* will have appropriate expertise and staff to monitor patients on a one to one basis, if needed.

In case an involuntary admission cannot be accepted, for the reasons cited above, *Erlanger Behavioral Health* will work with the referring source to identify alternative placement.

13.) Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services D.1. (Relationship to Existing Similar Services).

The narrative response on page 40 and utilization tables on page 41 are noted. However, please include MBMHI in the narrative response and utilization tables and submit a replacement page. In addition, please add a column in the tables to show % change from 2011 to 2014.

Response

As requested, *MBMHI* has been added to the table and the trend has been calculated between 2011 - 2014. The replacements for pages 40 and 41 are attached to this supplemental information.

However, applicant will point out that information on the *MBMHI* website indicates that …

> "*MBMHI* assists patients who are not typically served by the private service sector and have no other inpatient treatment resources available to them."

Thus, *MBMHI* itself categorically states that it does serve those who are covered by the private service sector.

It should be noted that *MBMHI* service area is the 52 counties in East Tennessee extending as far north as the Virginia and Kentucky state lines; the service area for *Erlanger Behavioral Health* is only 18 counties in Southeast Tennessee. The beds at *MBMHI* are utilized for patients with long term mental health issues, not those generally served in community based programs. Further, it is noted that in the *Agency's* staff report for the *Crestwyn Behavioral Health* application (no. CN1310-040), it was stated that "traditionally, the State operated mental health institutions care for long term mental health patients". Also, that "the applicant did not assess the impact the proposal would have on either of the State facilities".

14.) Section C, Need, Item 4.

Please provide overall patient origin by county for Erlanger Medical Center for the most recent year available. Include each county in Erlanger Behavioral Health's proposed service area.

Response

As requested, the patient origin by county for CY 2015 is below.

EHS -- In-Patient Origin By County
CY 2015

PSA Svc Area	HAMILTON, TN	15,499	*Tertiary Svc Area*	DEKALB, AL	372
				JACKSON, AL	516
				CHATTOOGA, GA	74
SSA Svc Area	BRADLEY, TN	2,110		FANNIN, GA	330
	MARION, TN	1,300		GILMER, GA	146
	GRUNDY, TN	333		GORDON, GA	207
	SEQUATCHIE, TN	909		MURRAY, GA	296
	BLEDSOE, TN	979		WHITFIELD, GA	667
	RHEA, TN	1,135		CHEROKEE, NC	218
	MEIGS, TN	196		COFFEE, TN	116
	MCMINN, TN	463		CUMBERLAND, TN	56
	POLK, TN	393		FRANKLIN, TN	215
	DADE, GA	616		LOUDEN, TN	17
	WALKER, GA	1,969		MONROE, TN	60
	CATOOSA, GA	1,692		ROANE, TN	16
				VAN BUREN, TN	51
				WARREN, TN	124

Svc Area	Cases	%
PSA	15,499	46.2%
SSA	12,095	36.1%
TSA	3,481	10.4%
All Other	2,470	7.3%
Total >>	33,545	100.0%

15.) Section C, Need, Item 5.

The utilization tables on page 50 are noted. However, please include utilization data for MBMHI in the tables and resubmit a replacement page. In addition, please include a column indicating the % change from 2011-2014.

Response

As requested, *MBMHI* has been added to the table and the trend has been calculated between 2011 – 2014. The replacements for pages 50 is attached to this supplemental information

However, applicant will point out that information on the *MBMHI* website indicates that …

> "*MBMHI* assists patients who are not typically served by the private service sector and have no other inpatient treatment resources available to them."

Thus, *MBMHI* itself categorically states that it does serve those who are covered by the private service sector.

It should be noted that *MBMHI* service area is the 52 counties in East Tennessee extending as far north as the Virginia and Kentucky state lines; the service area for *Erlanger Behavioral Health* is only 18 counties in Southeast Tennessee. The beds at *MBMHI* are utilized for patients with long term mental health issues, not those generally served in community based programs. Further, it is noted that in the *Agency's* staff report for the *Crestwyn Behavioral Health* application (no. CN1310-040), it was stated that "traditionally, the State operated mental health institutions care for long term mental health patients". Also, that "the applicant did not assess the impact the proposal would have on either of the State facilities".

16.) Section C, Need, Item 6.

Please provide the details regarding the methodology used to project 8,798 patient days during the first year of operation and 17,481 patient days during the second year of operation. The methodology must include detailed calculations or documentation from referral sources.

The total average daily census of 24.1 in Year One and 47.9 in Year Two of the proposed project is noted. Please break-out the proposed average daily census by Unit:

	Year One-ADC	Year Two-ADC
Adult Psychiatric Unit (24 beds)		
Gero Psychiatric Unit (24 Beds)		
Child and adolescent beds		

(18 beds)		
Chemical Dependency Unit (22 beds)		
Total	24.1	47.9

Please provide letters of referral from Community Mental Health Centers, Private Psychiatrists and Primary Care Physicians, etc.

Response

The ADC table has been completed.

	== Average Daily Census ===	
	Year 1	Year 2
Adult Psychiatric Unit (24 beds)	4.0	10.0
Gero Psychiatric Unit (24 beds)	12.0	18.0
Child & Adolescent Unit (18 beds)	4.0	10.0
Chemical Dependency Unit (22 beds)	4.1	9.9
Total	24.1	47.9

As requested, we have attached letters of support for *Erlanger Behavioral Health*. We have also attached comments from the general community which express *overwhelming* support for *Erlanger Behavioral Health* … these comments have appeared on websites in Chattanooga as well as other social media, such as *Facebook*.

17.) Section C. Economic Feasibility Item 1 (Project Cost Chart).

Line D. listing the estimated project cost as $24,067,600 is incorrect. Please revise and provide a replacement page.

Response

As requested, the error on the *Project Cost Chart* has been corrected. The replacement for page 52 is attached to this supplemental information request.

18.) Section C. Economic Feasibility Item 2 (Funding).

The March 11, 2016 funding letter from Acadia Healthcare referencing a proposed joint venture between Erlanger Health System and Acadia Healthcare is noted. However, the applicant states in the application there is not a current joint venture between Erlanger Health Systems and Acadia Healthcare. Please clarify.

What guarantee does the applicant have Acadia will actually fund the proposed project while Acadia currently has no relationship with the proposed project. Please clarify.

It is noted Acadia has a revolving line of credit that will finance a portion of the proposed project. Please submit a letter from a bank that identifies the revolving credit expected interest rate, term, and any anticipated restrictions or conditions.

What percentage of the proposed project cost will be financed through cash reserves and a revolving line of credit?

Please explain the reason the applicant is not funding the proposed project.

Response

A *Letter of Agreement* between *Erlanger Health System* and *Acadia Healthcare* is attached to this supplemental information. The agreement specifies that *Acadia* will fully fund design and construction of *Erlanger Behavioral Health*. Further, the *Letter of Agreement* with *Acadia* specifies that it's contribution will be cash and we confirmed with *Acadia* that this is their plan. As such, *Acadia* does not plan to utilize a credit facility to fund this project. Please see paragraph 3(c) of the *Letter of Agreement*.

19.) Section C, Economic Feasibility, Item 9.

Please complete the following chart for Year One of the proposed project.

Payor	Gross Revenue	% of Total Revenues

Medicare		
Medicaid/TennCare		
Commercial Insurance		
Self-Pay		
Total		

Response

The chart has been completed, as requested.

Payor	Gross Revenue	% Of Revenue
Medicare	$ 3,917,249	32.6%
TennCare/Medicaid	$ 3,086,317	25.7%
Commerical	$ 3,561,135	29.7%
Self Pay	$ 1,068,341	8.9%
Other	$ 368,758	3.1%
Total	$ 12,001,800	100.0%

20.) Section C, Economic Feasibility, Item 10.

Please provide copies of the balance sheet and income statement from the most recent audited financial statements with accompanying notes for Acadia Healthcare.

Response

A copy of the Form 10-K which was filed with the *Securities & Exchange Commission* for the fiscal year ended December 31, 2015, is attached to this supplemental information. The financial statements begin on page F-1 and the Auditor's report begins on page F-3, toward the end of the SEC filing.

21.) Orderly Development, Item 1.

Please clarify if the applicant will have transfer agreements with MBMHI.

Response

It is fully anticipated that the applicant will have a transfer agreement with *MBMHI*.

22.) Section C, Contribution to Orderly Development, Item 7 c.

Please provide the latest results of a state licensure survey and/or Joint Commission survey for Erlanger Health Systems with an approved plan of correction.

Response

The most recent accreditation letter from The Joint Commission is attached to this supplemental information, as requested.

23.) Section C, Contribution to Orderly Development, Item 8 and 9.

Please respond to these two questions for Erlanger Health Systems as a whole.

Response

There are no final orders or judgments against any professional licenses for *Erlanger Health System*. Further, there are no final orders or judgments against any entity or person with more than a 5% ownership interest in *Erlanger Health System*.

There are no final civil or criminal judgments for fraud or theft against any person or entity with more than 5% ownership interest in *Erlanger Health System*.

SUPPLEMENTAL #2
March 28, 2016
11:49 am

A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger Behavioral Health, LLC

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 24 of March, 2016, a Notary Public in and for the State of Tennessee, County of Hamilton.

Month Year

NOTARY PUBLIC

My commission expires October 10, 2016, 20____.

(Month/Day)

ROBIN S. DEBOLT
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Description	Section / Item
Quit Claim Deed	A-6
Letter Of Agreement - *Erlanger* & *Acadia*	A-6
Plot Plan	B-III-A
Inpatient Days - Tennessee Counties Of Patient Origin	C-I-a
Letters Of Support & Public Comments	C-I-6
Moccasin Bend - Website Page	C-1-a
Letter Of Accreditation - *Joint Commission*	C-II-1
CON Replacement Pages	
Acadia SEC Form 10-K	C-III-10

SUPPLEMENTAL #2
March 28, 2016
11:49 am

ATTACHMENTS

ACADIA HEALTHCARE

Direct Phone: 615-861-7339
Email: steve.davidson@acadiahealthcare.com

February 16, 2016

By Email (Joe.Winick@Erlanger.org)
Joseph M. Winick, FACHE
Senior Vice President
Planning, Analytics & Business Development
Erlanger Health System
975 E 3rd Street
Chattanooga, TN 37403

Re: Potential Venture for 80 Bed Behavioral Hospital – Letter of Intent

Dear Joe:

This letter is Acadia Healthcare Company, Inc.'s ("Acadia's") non-binding proposal ("Proposal") to enter into a joint venture arrangement (the "Transaction") with Erlanger Health System ("Erlanger") to develop, build and operate a new 80-bed inpatient psychiatric facility (the "Facility") that would provide a full range of inpatient and outpatient behavioral health services, on or near the Erlanger campus.

1. Proposed Transaction Structure. Based upon the information available to us to date, Acadia anticipates a two stage transaction structure. During the first stage, Erlanger would form a new entity (the "Venture") to own and operate the Facility which, initially, would be wholly-owned by Erlanger. The parties rights and obligations during the first stage would be governed by a Pre-Organizational Agreement. Upon obtaining a final, non-appealable Certificate of Need to develop and operate the Facility (the "CON"), the Transaction would enter the second stage during which Acadia would become an owner of the Venture and the Facility would be developed. The parties rights and obligations during the second stage will be governed by an Operating Agreement.

2. First Stage Responsibilities. During the first stage, Erlanger, at its expense, will organize the Venture and will apply for and pursue obtaining the CON. Erlanger will pursue the CON to a final, non-appealable result. The parties acknowledge that Acadia's intended relationship with the Venture will need to be disclosed during the CON process. Acadia will incur the costs of architecture, engineering and design necessary for the CON application for the Facility. Additionally, Acadia will deliver a letter to the Venture which will outline its commitment to fund the construction and development of the Facility which the Venture may use in connection with the CON application. The Venture shall obtain or shall obtain the right to acquire the real

estate for the Facility. Erlanger and Acadia would share equally, if necessary, the cost of an option on the real estate for the Facility.

3. **Second Stage Responsibilities.**

a. **Ownership of the Venture.** Upon the Venture obtaining a final and non-appealable CON, Acadia will become a member of the Venture. Erlanger and Acadia would own a percentage interest in the Venture in proportion to the value of their respective contributions. The value of the contributions, and the resulting relative percentage ownership of the Venture would be based upon an independent fair market valuation.

b. **Profit and Loss.** Each member's share of profits, losses and distributions in the Venture would be proportional to that member's percentage interest in the Venture.

c. **Contributions.** For its capital contribution to the Venture, Acadia would contribute cash in an amount to be determined, to be used for the design and construction of the Facility. For its capital contribution to the Venture, Erlanger would contribute its geriatric-psych business operated at Erlanger North Hospital and the Erlanger brand name for the Facility. Additionally, Erlanger will be credited with the value that the Venture has relating to the fair market, appraised value of the CON and the real estate for the Facility.

d. **Definitive Agreements.** The obligations of the parties to consummate the Transaction would be set forth in "Definitive Agreements" acceptable to each party in its sole discretion. The Definitive Agreements would detail the parties' rights and responsibilities concerning capital contributions, pro rata profit distributions, duties owed to the entity and the minority members, restrictions on transfers of interests, put and call rights, other restrictive covenants, triggers for the unwinding of the Venture, and other customary terms and conditions for a transaction of this type. The initial Definitive Agreement would be the Venture's Pre-Organizational Agreement which will have the form of the Operating Agreement for the Venture (the "Operating Agreement") and a license agreement for the Erlanger brand name attached. It is contemplated that the Operating Agreement would be fully negotiated at the outset of the Transaction but would be signed upon obtaining the CON.

e. **Working Capital Financing.** The Venture would not incur any debt other than a line of credit from Acadia, commencing upon obtaining the CON, of up to $5,000,000 for (i) working capital; (ii) general corporate purposes; and (iii) startup expenses. The parties contemplate that the Venture will purchase the real estate on which the Facility will be located using this capital, or, in the alternative, that Acadia will acquire such real estate and contribute it to the

Venture. The line of credit would bear interest at the prime rate plus 2%, would be due in full in 60 months, and would be repaid in full before distributions of profit by the Venture. The Venture would not guarantee debt of Acadia or Erlanger.

4. **Closing Conditions.**

a. The stage one closing would be conditioned on the following:

1. execution and delivery of Definitive Agreements;
2. approval of the Transaction by Acadia's Board of Directors;
3. approval of the Transaction by Erlanger's Board of Directors;
4. regulatory, legal, and operational diligence approval by Erlanger; and
5. regulatory, legal, and operational diligence approval by Acadia.

b. The stage two obligations of the parties including the requirement for Acadia to fund construction and the requirement for Erlanger to contribute its geriatric-psych unit to the Venture shall be conditioned on the following:

1. no material adverse change in the CON, licensure category, or the prospects of the Facility;
2. approval of a CON for the Facility for at least 80 psychiatric beds;
3. zoning and similar land use approvals for the Facility's construction issuing from the appropriate governmental authorities;
4. receipt of a written opinion or opinions from independent third party appraiser(s) with expertise in healthcare transactions, that the consideration paid or contributed in exchange for member interests in the Venture is consistent with fair market value.

5. **Governance.** Beginning with stage two, the Venture would be subject to oversight by a "Board of Directors" appointed by the parties and voting based on the respective ownership interests represented, provided that in no event shall any party have less than two Board members. It is anticipated Acadia would have a controlling interest in the Venture and appointment rights over a majority of the Board of Directors. The following Board of Directors decisions would require approval of (a) a majority of the appointed individuals sitting on the Board of Directors and (b) at least one Board representative of each of the parties:

a. approving the Venture's strategic business plan;
b. determining the need for additional capital contributions;
c. approving the location and design of the Facility and construction budgets;
d. extraordinary capital expenditures including long term leases;
e. approving incurrence of extraordinary debt;
f. expanding or reducing the number of beds at the Facility;
g. admitting any new member;

h. creating or issuing additional membership interests and/or new classes of membership interests;

i. granting any lien or security interest (except for those in the ordinary course of business not in excess of $1,000,000) on or in any of the Venture's assets or property;

j. making loans to, or acquiring equity interests in, any other person or entity;

k. selling or otherwise disposing of assets of the Venture, other than in the ordinary course of business;

l. agreeing to any contract restricting the Venture's right to make distributions to its members, or agreeing to pay any distributions in respect of member units in any form other than cash or in any manner other than to the members in accordance with their membership percentage interests;

m. amending the Venture's articles or organization, operating agreement, or name;

n. entering into, renewing or terminating any lease, contract or agreement or any other transaction or arrangement (whether or not involving payments or remuneration) between the Venture and any member or affiliate of a member;

o. approving any transfer of the equity interests held by a member, whether by direct sale, merger, or exchange;

p. approving any merger, sale, restructuring, or recapitalization of the Venture or causing the Venture to convert to a different form of entity;

q. filing a petition requesting or consenting to an order for relief under the federal bankruptcy laws or to dissolve the Venture;

r. leasing any portion of the real property owned by the Venture other than in the ordinary course of business;

s. redeeming or repurchasing by the Venture of any member units, other than on a pro rata basis to all members;

t. hiring and retention of the CEO, CFO and CNO of the Facility;

u. entering into any corporate integrity agreement or settlement agreement in connection with any government investigation or whistleblower suit; and

v. making other extraordinary material decisions as set forth in the Definitive Agreements.

The Definitive Agreements would include a mechanism for resolving certain deadlocks that may arise in connection with a governance decision.

6. Financial Statements. The Definitive Agreements will provide for the delivery of annual Acadia-level consolidated and Venture-level audited, and monthly Venture-level unaudited financial statements of the Facility.

7. Charity Care Policy. The Operating Agreement will contain covenants ensuring that the Venture (i) is operated and managed in a manner that does not jeopardize Erlanger's tax-exempt status, and (ii) recognizes and promotes Erlanger's objective of providing charity care. Specifically, the Operating Agreement will provide that the Venture will provide healthcare services for a broad cross-section of the community, adopt high standards for the quality of

patient care, provide a reasonable level of charity care to the community served by the Venture and collaborate with Erlanger on the provision of uncompensated care.

8. **Corporate Office Services; Management.** Pursuant to a services agreement to be entered into between the Venture and Acadia, Acadia's corporate office would provide corporate office management services to the Venture, to include support in the following areas: operations management, finance and accounting, legal advice and counsel, internal audit, clinical quality and compliance, risk management, insurance, human resources, recruiting, payroll, information technology, tax, billing and collecting, marketing, managed care contracting, and business office support. Acadia would charge the Venture a management fee equal to 2% of the Venture's revenue for these corporate office services, and would pass through to the Venture without markup the following expenses: (a) the actual reasonable costs of outside consultants, legal counsel, tax counsel and outside auditors; (b) a proportional amount of Acadia's facilities' costs for software licenses, insurance and employee benefits; and (c) the direct costs of Adadia's call center, web design and marketing staff to the extent dedicated to marketing the Facility, not to exceed .05% of annual Venture revenue, the actual reimbursable third party expenses of Acadia's corporate office staff, incurred in providing services to the Venture, in accordance with Acadia's Expense Reimbursement Policy. As the anticipated majority member, Acadia would be responsible for the day-to-day operations, management and control of the Facility. Acadia would consolidate the results of the operations of the Facility with its company financial statements.

9. **Noncompetition.** The Definitive Agreements would provide that Acadia and Erlanger would covenant and agree with one another and each other's affiliates that, during the Non-Compete Period (defined below) and within the Non-Compete Area (defined below), they would not directly or indirectly, with the exception of the Facility and specified other exceptions, own, acquire, lease, manage, consult for, serve as agent or subcontractor for, finance, invest in, own any part of or exercise management control over any facility or business that primarily provides services that are the same or similar to the services provided by the Facility, provided that the non-compete will exclude care provided by Erlanger in any emergency department or any service provided in an acute care setting which is accompanied by or incidental to a general medical condition which requires the patient's presence at an Erlanger facility. The "Non-Compete Period" would, for each member respectively, commence on the date of such member's acquiring any membership interest in the Venture (each a "Membership Date") and terminate on the second anniversary of such member's liquidation or termination of all such membership interests. The "Non-Compete Area" would mean the area within a twenty-five (25) mile radius of the Facility, including any satellite locations thereof. In addition, during the Noncompete Period, the members shall not solicit for employment or employ any person (at or above a certain level) who is then employed by the Venture or a party, subject to exceptions for general solicitation activity not targeted as such persons.

10. **Access and Information.** The parties will furnish to one another and their respective representatives such CON, licensure, regulatory and such other information relating to the Transaction as another party or its representatives may from time to time reasonably request.

All such access, investigations, contacts and inspections to be conducted by the requesting party and its representatives shall be conducted in consultation with the other parties and in such a manner as not to interfere unduly with the normal conduct of the other parties' business.

11. Confidentiality; Public Announcement. The terms of this letter are subject, in all respects, to the parties' Memorandum of Understanding July ___, 2015. The timing and content of any announcements, press releases or any public statements concerning the Transaction (including the CON process) shall be determined by mutual agreement of the parties, unless, with respect to Acadia, in the judgment of Acadia upon advice of counsel, disclosure is otherwise required by Acadia by applicable law or by the applicable rules of any stock market on which Acadia's securities are listed or quoted, provided that Acadia shall use commercially reasonable efforts consistent with such applicable law to consult with Erlanger with respect to the text thereof.

12. Exclusivity. The parties contemplate the expenditure of substantial sums of time and money in connection with legal, accounting, financial, and due diligence work to be performed in conjunction with the proposed transaction prior to execution of the Definitive Agreements. For purposes of inducing one another to execute this Letter of Intent, during the period from the date of acceptance of this Letter of Intent specified below to March 31, 2016, the parties and their directors, officers, affiliates, agents and employees shall not, without the prior written consent of the other parties hereto, directly or indirectly, solicit or entertain offers from, negotiate with, or in any manner encourage, discuss, accept or consider any proposal of any other person relating to the acquisition, construction, joint venture, or management of a psychiatric or substance abuse facility similar in nature and location to the proposed Facility.

13. Nonbinding Effect. Except as provided in paragraphs 11-15 (the "Binding Provisions"), this Letter of Intent will not create any binding legal commitments between the parties but will serve only to evidence the parties' present intentions with respect to a possible transaction.

14. Termination of Letter of Intent. This Letter of Intent shall terminate upon the earliest to occur of (i) written notice of termination by either party to the other or (ii) the execution of Definitive Agreements. The Binding Provisions shall survive the expiration or termination of this Letter of Intent.

15. Governing Law. This Letter of Intent shall be governed and construed in accordance with the laws of the State of Tennessee without regards to principles of conflicts of laws.

We are very pleased to submit this Proposal. The Transaction is a priority for Acadia and we are prepared to commit the necessary resources to complete the Transaction expeditiously. Any questions regarding this Proposal should be directed to Steve Davidson, Chief Development Officer, at 615-861-6000 or via email at steve.davidson@acadiahealthcare.com. We thank you for your consideration and look forward to working with you.

SUPPLEMENTAL #1
March 28, 2016
11:49 am

If you are in agreement with the terms of this Letter of Intent, please sign and return one copy to us and each party should retain one copy for its records.

Sincerely,

Steve Davidson
Chief Development Officer

Agreed and Accepted:

Emanger Health System
By: Joseph M. Winck
Its: SVP

SUPPLEMENTAL #2
March 28, 2016
11:49 am

Description	Section / Item
Inpatient Days - Tennessee Counties Of Patient Origin	C-I-a
Moccasin Bend - Website Page	C-1-a

Analysis Of Inpatient Days By County Of Patient Origin
For Mental Diseases & Substance Abuse

	======== Age Group 0-17 ========			======= Age Group 18-64 ========			======== Age Group 65+ =========		
	MDC 19 Mental Dis.	MDC 20 Sub. Abuse	Total	MDC 19 Mental Dis.	MDC 20 Sub. Abuse	Total	MDC 19 Mental Dis.	MDC 20 Sub. Abuse	Total
Hamilton, TN	2,960	1	2,961	5,995	1,279	7,274	1,405	205	1,610
Bradley, TN	721		721	2,837	529	3,366	380	24	404
Marion, TN	144		144	642	64	706	335	10	345
Grundy, TN	13		13	556	66	622	450	11	461
Sequatchie, TN	172		172	392	19	411	68	9	77
Bledsoe, TN	80		80	225	47	272	68	22	90
Rhea, TN	229		229	448	145	593	180	13	193
Meigs, TN	52		52	390	47	437	108		108
McMinn, TN	415		415	1,520	232	1,752	225	1	226
Polk, TN	13		13	342	78	420	41	4	45
Coffee, TN	230	1	231	1,558	257	1,815	618	44	662
Cumberland, TN	886		886	828	74	902	674	29	703
Franklin, TN	111		111	958	99	1,057	735	43	778
Loudon, TN	199		199	688	117	805	266	23	289
Monroe, TN	1,313		1,313	980	108	1,088	217	49	266
Roane, TN	284		284	879	129	1,008	309	9	318
Van Buren, TN	13		13	102	5	107	122		122
Warren, TN	92		92	1,042	157	1,199	558	6	564
Total	7,927	2	7,929	20,382	3,452	23,834	6,759	502	7,261

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, CON and Joint Annual Report.

SUPPLEMENTAL #2
March 28, 2016
11:49 am

Hospitals

Moccasin Bend

MBMH Patient & Visitors Information

MBMH Patient Rights & Responsibilities

Middle Tennessee

Western

Memphis

Crisis Services & Suicide Prevention

Patients & Families

Help After Hospitalization

Jobs at the Hospitals

Moccasin Bend

Moccasin Bend Mental Health Institute

Mary C. Young, Chief Executive Officer
100 Moccasin Bend Road
Chattanooga, TN 37405
423-265-2271

ABOUT

Moccasin Bend Mental Health Institute (MBMHI) is a psychiatric hospital that serves 33 counties in East Tennessee. It was founded in 1961 in Chattanooga, Tennessee. The hospital offers 4 acute psychiatric care units and 2 long-term care units, comprising a total of 138 adult psychiatric beds. Hospitalizations are on a voluntary or involuntary basis, or patients can also be referred by the court system for pre-trial evaluations.

The **mission** of Moccasin Bend Mental Health Institute is to provide quality psychiatric services to individuals with a severe and persistent mental illness. The staff works together with patients to promote recovery and ensure their successful return home and reintegration into the community.

COUNTIES SERVED

Anderson	Cumberland	Jackson	Monroe	Smith
Bedford	DeKalb	Jefferson	Morgan	Stillman
Bledsoe	Fentress	Johnson	Overton	Unicoi
Blount	Franklin	Knox	Pickett	Union
Bradley	Grainger	Lincoln	Polk	Van Buren
Campbell	Greene	Loudon	Putnam	Washington
Carter	Grundy	Macon	Rhea	Warren
Claiborne	Hamblen	Marion	Roane	White
Clay	Hamilton	McMinn	Scott	
Cocke	Hancock	Meigs	Sequatchie	
Coffee	Hawkins	Monroe	Sevier	

ADMISSION

Moccasin Bend Mental Health Institute assists patients who are not typically served by the private service sector and have no other inpatient treatment resources available to them. Most patients have a severe and persistent mental illness and are hospitalized on an emergency, involuntary basis. The hospital is an authorized provider under TennCare.

**

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Description	Section / Item
Letters Of Support & Public Comments	C-I-6

SUPPLEMENTAL #2
March 28, 2016
11:49 am

UT erlanger
Behavioral Health

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
502 Deaderick Street, 9th Floor
Nashville, TN 37243

RE: Erlanger Behavioral Health

Dear Ms. Hill:

The majority of psychiatric patients from the surrounding Chattanooga area come to Erlanger's Emergency Department for acute emergencies. Over the last 10 years, psychiatric visits to Emergency Departments across the country have increased and ours is no exception. Since 2013, the number of patients being transferred from Erlanger's ED to psychiatric inpatient facilities has doubled, mirrored by a drastic increase in the number of boarding hours. It is widely recognized in this region that there is a wide disparity between need and available resources.

As Chief of Behavioral Health at Erlanger, I am extremely excited to give my support for the new behavioral health hospital that will expand the current capacity for mental health treatment and support in this area. This is an incredible opportunity to improve access to care for our patients with mental illness. I am proud to be a part of Erlanger who by providing these services will change the landscape of behavioral health in this community and the lives of so many people.

Sincerely,

Jennie Mahaffey, M.D.
Chief of Behavioral Health
UT Erlanger Behavioral Health
979 East 3rd Street, Ste A-443
Office:(423)778-2965
Fax: (423)778-2966

SUPPLEMENTAL #2
March 28, 2016
11:49 am

THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER

COLLEGE of MEDICINE

Office of the Dean
960 East Third Street
Suite 100
Chattanooga, Tennessee 37403
Tel: (423) 778-6956
Fax: (423) 778-3672

March 24, 2016

Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Dear Ms. Hill:

Please accept the full support from the University of Tennessee College of Medicine Chattanooga for a new proposed 88 bed behavioral health hospital. As you know, this will fill a critical patient care need in our region.

Our medical school provides the third and fourth years of medical student education and our 180 residents and fellows participate in ten residency and ten fellowship programs. A critically important part of the third year curriculum is in psychiatry and these new services will significantly enhance opportunities for education. We also would be interested in exploring new opportunities for graduate medical education expansion in behavioral health should appropriate, sustainable funding sources become available.

Thank you for your consideration of this important enhancement for patient care and education.

Kind regards,

Robert C. Fore

Robert C. Fore, EdD
Professor and Interim Dean

children's
Hospital at Erlanger

T.C. Thompson Children's Hospital Campus
910 Blackford Street · Chattanooga, TN 37403
423.778.KIDS (5437)
www.erlanger.org/childrens

March 23, 2016

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
502 Deaderick Street, 9th Floor
Nashville, TN 37243

RE: Erlanger Behavioral Health

Dear Ms. Hill:

Please accept this letter of support for the Certificate of Need application that Erlanger Health System has filed to establish a new 88 bed behavioral health hospital. As the CEO of Children's Hospital at Erlanger, I am very aware of the communities need for pediatric, adolescent and adult behavioral health services. On any given day, we have multiple patients in our emergency department, or on our inpatient floor, being held while searching for any level of psychiatric or behavioral support. Many of our patients have substance abuse issues and/or are in real need of both acute and chronic psychiatric care. This problem has continued to grow and was a recent topic for our Children's Hospitals of Tennessee (CHAT) meeting in Nashville.

I have recently met with several pediatric practices and ask them what they need from our health system. The number on answer has always been, "please help us with our behavioral health patients." These services simple do not currently exist in our community.

Thank you for your consideration of this very important initiative. If further information is needed or if you have questions, please do not hesitate to contact me.

Sincerely,

Don Mueller

Don Mueller, FACHE
Chief Executive Officer
Children's Hospital at Erlanger
office: (423) 778-2298
email: don.mueller@erlanger.org

children's
Hospital at Erlanger

THE UNIVERSITY of TENNESSEE COLLEGE of MEDICINE CHATTANOOGA

children's
Hospital at Erlanger
T.C. Thompson Children's Hospital Campus
910 Blackford Street · Chattanooga, TN 37403
423-778-KIDS (5437)
www.erlanger.org/childrens

March 24, 2016

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
502 Deaderick Street, 9th Floor
Nashville, TN 37243

RE: Erlanger Behavioral Health

Dear Ms. Hill:

I wanted to send you a note to let you know that as the Clinical Administrator of Children's Hospital at Erlanger, I am in full support of the Certificate of Need application that Erlanger has filed to establish a new 88 bed behavioral health hospital. We have had an increase in the number of adolescent patients seen in the Children's Emergency Department over the past year. Our Pediatric Emergency physicians have spoken out repeatedly about the need that our current patients have for additional behavioral health facilities and programs. Adolescent beds for psychological issues are hard to come by and any additional beds would be a welcome addition to our area.

Thank you for your consideration of this very important initiative. If further information is needed or if you have questions, please do not hesitate to contact me.

Sincerely,

Leslie Phelps, MSHCA, BSN, RN
Clinical Administrator
Children's Hospital at Erlanger
910 Blackford Street
Chattanooga, TN 37403
Lesie.phelps@erlanger.org
423-778-6058

erlanger

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Re: Erlanger Behavioral Health

Dear Ms. Hill:

I am writing to advise you that the primary care and specialty physicians, numbering in excess of 200, employed by Erlanger Health System, are in full support of the Certificate of Need application that Erlanger has filed to establish a new 88 bed behavioral health hospital. Our physicians have spoken out repeatedly about the need that our current patients have for additional behavioral health services, facilities and programs. Many of the patients we currently serve on an inpatient and outpatient basis have psychological, psychiatric and medical comorbidities. We have already established a behavioral health division; however, more programming and resources are needed to address the significant need in our community and the surrounding region.

Thank you for your consideration of this very important initiative. If further information is needed or you have questions, please do not hesitate to contact me.

Sincerely,

Steven H. Burkett
Sr. Vice President, Physician Services
Erlanger Health System

SUPPLEMENTAL #2

Opinion

Thank You, Erlanger, For Offering Desperately Needed Help For The Mentally Ill

Saturday, March 12, 2016

The most under-served medical conditions that exist are mental illness. We have this artificial line of separating mental health from medical illness, mostly due to insurance companies. Greedy insurance companies and ACA requirements have pushed the majority of licensed psychiatrists to a private pay system, which is contrary to the best interest of the public and leaves the poor without treatment.

The fact is mental health problems are medical problems, and licensed psychiatrists and medical physicians are required to make meaningful improvements in the stability and lives of the mentally ill.

No one is going to counsel their way out of bi-polar, and the majority of serious mental illness.

The majority of our mentally ill population are under-treated, if treated at all. The mentally ill fill the jail, comprise a large majority of the homeless, and have a much greater propensity to drug abuse and addiction. Yet, the mentally ill have the least access to medical care and treatment from qualified licensed physicians and psychiatrists.

While unfounded, public perception of mental illness is an obstacle to treatment. There is a pervasive shortage of licensed psychiatrists and facilities in Hamilton County. That is a fact - we simply do not have enough licensed psychiatrists or facilities in Hamilton County.

It is a myth that the mentally ill can be treated by simply talking to a counselor. This is a completely inadequate approach that has mass populations of the mentally ill missing appropriate and individualized evaluation and treatment. The mentally ill should have complete medical evaluations. Often times there are root medical causes that perpetuate mental illness. The mentally ill are not receiving these medical clearances to identify or rule out root medical cause.

While social workers and counselors should be a part of the equation, the drivers should be licensed medical physicians, psychiatrists, and facilities for treatment.

Problem is, we don't have enough psychiatrists or facilities in Hamilton County.

Currently, the two primary existing mental health facilities are overflowing and often times have patients stacked in their hallways. These facilities mean well, and do the best they can with completely inadequate resources to achieve even a reasonable standard of care.

The Hamilton County Jail is also housing many mentally ill patients as these treatment facilities. Sometimes, the jail is the only option.

The mentally ill have a propensity to self medicate, which is a direct path to the justice system. The relationship between drug abuse and mental illness is not a causal one. The Hamilton County Jail is the front line of mental health, and that is really messed up. I respect the job the jail is doing with virtually no resources due to our inept elected Hamilton County Commissioners that have denied funding requested by the sheriff for almost two decades. Yep, inept Hamilton County Commission, that is what I said.

The mentally ill at the jail should be receiving mental health triage by licensed professionals. Johnson Mental Health only responds if requested. If any facility in our region needed an on staff licensed mental health professional, it would be the Hamilton County jail.

Our Hamilton County Commissioners are directly responsible for the Hanoi Hilton conditions at the jail, period. Any government that allows mentally ill people to be stacked in cells urinating over one another sleeping in the floor needs to be sued for civil rights violations. Will add that to my to do list.

In short, the standard of care for the region's mentally ill is deplorable and missing the primary components of real physicians that can evaluate medical needs including medication and facilities to house the mentally ill. No one is going to counsel their way out of a large majority of mental illness.

A reasonable standard of care cannot exist within the current framework in Hamilton County that lacks access to licensed psychiatrists and facilities.

Erlanger Hospital just published that they wish to gain authority from the state of Tennessee regulatory board for a 200-bed facility. Erlanger is a real medical leader and has identified the greatest medical need in the community.

We would not send a diabetic out of an emergency room without evaluation and treatment.

Why are the mentally ill sent out of emergency rooms untreated or even given a course of action?

Erlanger Hospital, the facility you propose is greatly needed. Please share with the public what we can do to support your proposal.

Thank you, Erlanger Hospital.
April Eidson

March 20, 2016

Congratulations, Earl, On Your Radio Hall Of Fame Induction

To Earl Freudenberg, My heartiest congratulations in honor of your induction into the Radio Hall of Fame. You have been in my hall of fame for many, many years already. ... (click for more)

March 20, 2016

Debunking The Social Programs Myth

Social programs didn't destroy the black family. Mass incarceration and excessive, over the top policing in primarily black communities did. When those same rules and laws are deployed, applied ... (click for more)

March 20, 2016

Roy Exum: My Pal Johnny Hennen

About 10 days ago, as I sat in the pre-dawn chill like I do each day with my three prayers lists, I took my pencil and crossed my beloved friend Johnny Hennen's name off the "B" list, and moved ... (click for more)

SUPPLEMENTAL #2
March 28, 2016
11:49 am

Winick, Joe

From: Charles, Pat
Sent: Monday, March 14, 2016 2:48 PM
To: Gentry, Gregg; Winick, Joe
Subject: Incredible, positive response on media online stories re new hospital

Importance: High

The response on local media's Facebook posts to our new hospital plans has been OVERWHELMINGLY positive. Shortly after the Times Free Press posted their story online, it got 583 likes and 151 shares, with some high praise from Judge Gary Starnes. And this was from a **Saturday** story.
Channel 3's online story quickly generated 264 likes with 78 shares. Again, with several endorsements and praise from Judge Gary Starnes, who is over Chattanooga's Mental Health Court. I would be willing to bet he would write a letter of endorsement – or even accompany you to CON hearing if his schedule permitted. Channel 12's online post led to 122 likes, 29 shares.
I have never seen so many uniformly positive comments on anything (Erlanger or otherwise) in recent months. Everyone is talking about need, how long overdue this type facility is in Chattanooga. Will be glad to provide these comments to you, Joe, if you want to include in your CON reports regarding community response.
And I certainly recommend sharing these comments with our board members.

Pat Charles
Director, Corporate Communications
Erlanger Health System
Office: (423) 778-2922
Fax: (423) 778-7615

SUPPLEMENTAL #2
March 28, 2016
11:49 am

News 12 Now
March 13 at 8:39am ·

#CHANews Erlanger proposes $25M behavioral health hospital that would provide 200 jobs

Erlanger proposes $25M behavioral health hospital - News 12 Now

CHATTANOOGA, Tenn. (AP) – Chattanooga's Erlanger Health System is hoping to build a $25 million behavioral health hospital that it says would eventually...

HTTP://BIT.LY

Like **Comment** **Share**

133 Top Comments

31 shares

Write a comment...

JoAnn Antosh Temple Bless you Erlanger! Those us us who love someone with mental illness know what this hospital could mean.

Like · Reply · March 14 at 6:21pm

Susie Que Erlanger should concentrate on building the new children's hospital before they start this one.

Like · Reply · 3 · March 13 at 9:38am

Jason Whiteside Boy how I wish they'd take over Rhea Medical. It's a nice hospital, but to work there 4 1/2 years for less than 10.00 a hour for a job that even the nurses will not do is ridiculous!

Like · Reply · 2 · March 13 at 9:00am

Paula Crowe What job?

Like · Reply · March 14 at 11:54am

Write a reply...

164

SUPPLEMENTAL #2
March 28, 2016
11:49 am

Eva Pate What a blessing that would be!!!!!

Like · Reply · March 14 at 11:15am

Write a comment...

SUPPLEMENTAL #2

165

March 28, 2016
11:49 am

Chattanooga Times Free Press shared a link.
March 12 at 9:00am ·

Erlanger asking for permission to build $25 million behavioral health hospital

Erlanger Health System is asking the state for permission to build a $25 million behavioral health hospital that eventually would employ 200 people, according...

TIMESFREEPRESS.COM

Like **Comment** **Share**

584 Top Comments

152 shares

Write a comment...

Heather Wilson Omg YES! Very much needed. You would be so surprised to know how many psych pts we see in our ER daily. I would be elated to see this happen!
Like · Reply · 23 · March 12 at 9:13am

Becky Hammond Praying this happens. as it is so needed in this community and across the US.mental illness needs to be recognized as an urgent medical condition.
Like · Reply · 20 · March 12 at 9:36am

Manon Kraus Whatever happened to Park Ridge Valley? That is a psyche hospital that has been in Chattanooga for some time.
Like · Reply · March 13 at 6:52pm

Heather Wilson It's still there.
Like · Reply · March 14 at 10:21am

Write a reply...

Gary Starnes Finally. This is definitely needed to address the mental health issues confronting our entire system particularly the court system. Thank you Erlanger.

Like · Reply · 8 · March 12 at 10:50am

Kymberly Brown It's needed because primary Cafe doctors do not know how to treat mentally ill patients just provide you all these pills and they don't even know what pills they ate suppose to, plus you end up taking so many different ones which can make things worse. There is not many places to go here for help. They do need it.

Like · Reply · 5 · March 12 at 11:16am

Chris Beasley Certificate of Need (CON) laws are ridiculous, unconstitutional, and they hurt consumers. They are being challenged in court all over the country. In what other industry do you need permission from both the government AND your competitors to open a bus... See More

Like · Reply · 3 · March 12 at 10:22am

Tim Salmon That will have some haters who own stock in CCA highly P.O.ed.
Private prison's next step will be to open such facilities.

Like · Reply · 3 · March 12 at 1:07pm

MikeNikki Flanigan Will they actually hold ppl that need help that is the question. I've seen too many people talk there way out of help when they truly need it. -nikki

Like · Reply · 1 · March 12 at 10:29am

Jay Privett The ironic thing about libtards is that while they whine about the upper crust, the 1% that own 90% of the wealth, they are from that same 1%. These are the kind of people who look for any excuse to take the easy way out and alleviate themselves of any and all responsibility from their own mistakes. Thus voting for Bernie Sanders.

Like · Reply · March 12 at 3:27pm

John Kleinmark Yes my father gave me a small loan of 100 million and I don't know why all parents do not do this for their children.....

Like · Reply · 3 · March 12 at 10:27pm · Edited

Heather Wilson What does this comment have ANYTHING to do with this thread? Seriously. Read the actual article.

Like · Reply · 3 · March 13 at 9:21am

Jay Privett Ok dyke.

Like · Reply · March 13 at 1:59pm

Samantha Trantham Heather Wilson I agree with you. I do not think people truly understand until they see these patients first hand. Very sad.

Like · Reply · 1 · March 14 at 10:23am

Heather Wilson Jay Privett I'm married. To a man...not that it matters. Since you have nothing else better to say, or intelligent...

Like · Reply · 1 · March 14 at 10:23am

Jay Privett Mhm.

Like · Reply · March 14 at 1:41pm

Write a reply...

Tammy Steele Sure would help the community!! Please do it!!

Like · Reply · 7 · March 12 at 9:17am

Michelle Mann-Harris Yes, Moccasin Bend is still around. We are a 150 bed facility.

Like · Reply · 7 · March 12 at 9:49am

Julie Ellen Voyles And still too small to serve this community properly.

Like · Reply · 1 · March 12 at 11:33pm

Write a reply...

167

SUPPLEMENTAL #1
March 28, 2016
11:49 am


Heather Ward Where can I get a business card so I can hand them out to my co-workers?
Like · Reply · 4 · March 12 at 11:21am


Kim Simon Brown Yes, please. Great idea for an overlooked segment of our population.
Like · Reply · 2 · March 12 at 12:07pm


Dree Mott This would be so great!
Like · Reply · 1 · March 12 at 10:56am


Tim Warren That hospital played a big part next to God in saving my dad's life in the 70's
Like · Reply · March 12 at 6:25pm


Shawda Covington Or u could give your employees a raise since they haven't had one in yrs!!!
Like · Reply · March 12 at 1:08pm


Jennifer Tipton We just got one in January.
Like · Reply · 2 · March 12 at 3:59pm

Write a reply...


Charlie Branson Thinkin that that would be a great investment.
Like · Reply · March 12 at 2:13pm


Tiffany Harris Clarissa Souci weren't we all just talking about something like this?! Cool!
Like · Reply · 1 · March 13 at 9:55pm


Clarissa Souci Yes!
Like · Reply · 1 · March 13 at 9:56pm


Clarissa Souci I pray this happens! Much needed for sure.
Like · Reply · 1 · March 13 at 9:59pm


Tiffany Harris Me too!
Like · Reply · 1 · March 13 at 10:00pm

Write a reply...


Jose Fernandez I think that is an amazing idea. Looking forward to hear the result this June. I love Erlanger.
Like · Reply · March 12 at 10:01pm


Melissa Gannon Or what if 25 M were poured into Moccasin Bend.
Like · Reply · March 12 at 2:48pm


Chris Beasley Why would Erlanger put $25 million into a hospital owned by the State of Tennessee? Mocassin Bend also does not serve children and adolescents.

Mocassin Bend has a place as the provider of last resort for severely ill adult psychiatric patients with no family or financial support or with court ordered confinement. They don't serve the local community, they serve the regional one.

Teens with depression or an eating disorder don't go to Mocassin Bend, the two places would treat entirely different groups.

Like · Reply · 2 · March 13 at 10:12am

Write a reply...


Barry Wilson The democrats need a place to go and hang out.
Like · Reply · March 13 at 7:39pm


Terry Pickens Yes, most drivers on the road need this help.
Like · Reply · March 12 at 2:58pm


John Kleinmark Mental health clinics are recruiting stations for the Republicans.
Like · Reply · March 12 at 10:28pm


Yvonne Stoudermire Very Much Needed!!!
Like · Reply · 4 · March 12 at 9:05am


Olivia Long Woohoo!
Like · Reply · 1 · March 12 at 10:55am


Brenda Rayburn Wingo Very, very needed! I hope it is approved.
Like · Reply · March 12 at 5:23pm


Monique Dion Well needed
Like · Reply · March 12 at 10:17am


Diana Ledford Carlock It is truly needed
Like · Reply · March 12 at 3:41pm


Kristi Wilkey This is so needed!
Like · Reply · March 12 at 9:10pm


Aaron Kyle Buchanan Build it!
Like · Reply · March 13 at 8:43am


Bobby Stewart Jr. Let it happen
Like · Reply · March 12 at 6:37pm


Julie Ellen Voyles It's about time!!!!
Like · Reply · March 12 at 11:32pm


Alma Knowles Please build I
Like · Reply · March 12 at 9:44am


Melanie Bohannon Oliver Much needed!!!!
Like · Reply · March 12 at 10:25am


Dusty Horne Awesome!
Like · Reply · March 12 at 7:56pm


Zena Hanner Great!!
Like · Reply · March 12 at 4:42pm


Jodi Shapuras Whitted Amazing news!
Like · Reply · March 12 at 9:52am


Katrina Shipman
Like · Reply · March 13 at 3:49am


Trent Wamp YES YES YES!
Like · Reply · March 12 at 1:15pm

SUPPLEMENTAL #1

169

March 28, 2016
11:49 am

WRCB Channel 3 Eyewitness News
March 12 at 4:38pm ·

$25M behavioral health hospital proposed for Chattanooga

Read more at: http://www.wrcbtv.com/.../25m-behavioral-health-hospital-prop...

Like **Comment** **Share**

266 Top Comments

77 shares

Write a comment...

Gary Starnes This is badly needed in this area to treat patients with mental illnesses. It will be particularly helpful to our criminal justice system that is currently overwhelmed with folks charged with crimes who have mental illnesses. For example, 46% of those currently in jail have mental illnesses and it costs approximately $250,000 per year to give them badly needed medication. Our recently implemented mental health court has been very successful but beds, inpatient treatment, and additional mental health professionals will be very welcome. Thank you Erlanger.

Like · Reply · 18 · March 12 at 8:03pm

Jodi Renfro What are the staistics on the ones who are in jail that have been diagnosed outside of jail that are currently not being adequately treated in jail?

Like · Reply · 1 · March 12 at 9:05pm · Edited

Gary Starnes I'm not sure about those stats. But let me give you another staggering number. A few short years ago, the legislature and/ governor (I believe the Bredesen administration) closed several mental health facilities up and down east Tennessee to "save money." What happened next? They were all sent to Moccasin Bend Mental Health (MBMH). Currently, 54 of 95 counties are sending mental health patients to MBMH with "zero" additional funding and no upgrades to MBMH which was built in the late 70s. This has overwhelmed MBMH and Hamilton County. This is astounding to say the least.

Like · Reply · 3 · March 12 at 9:39pm

Jodi Renfro I agree Judge Starnes it is astounding. But there are so many more currently incarcerated who are not getting the help they require. I have a son at Silverdale that was diagnosed as high

functioning autism and drepression who only gets his meds when medical decides to have med call. A public defender who isn't worth a crap and a prosecutor who, well I cant say what she is. I have called Silverdale and the excuse I get is they are severely understaffed. I have asked the PD to help and I get the same excuse. Sorry I brought up my families personal experience but I also wanted to show the lack of help available to inmates as well.

Like · Reply · 1 · March 13 at 3:02pm

Stephanie Coley Villalba It's a revolving door. Lack of mental healthcare facilities leads to more inmates in jails and prisons where they get no care etc. If the one is taken care of and there are more facilities and funding then it should free up a lot of over populating in the jail systems.

Like · Reply · March 13 at 4:07pm

Gary Starnes Ms. Renfro, if you will send me a private message with your contact number, I will check on your son on Monday. Thanks.

Like · Reply · 1 · March 13 at 5:57pm

Kristy Brooks Posey There's also many living on the streets. That administration that chose to "save money" must be very uneducated and have no loved ones with mental health issues!

Like · Reply · 1 · March 13 at 6:24pm

Write a reply...

Diane Whited I hope they keep it clean..that is absolutely the dirtiest place ever. And u can forget about asking 4 anything. Took hour 2 get my mom pain meds..

Like · Reply · 4 · March 12 at 6:31pm

Wendy Grider I know. Last time I was there empty Coke can in what I call cubicle rooms where they saw patients since ER was running over. Time before last in ER went in with foot injury & left with flu since they didn't enforce mask rules

Like · Reply · 1 · March 12 at 9:13pm

Write a reply...

Cheryl Lynn Curtis I think if we are truthful with ourselves, we can see state and federal dollars coming down the pipeline for opioid addiction treatment. Reimbursements in that particular area of mental health will be plentiful so Erlanger stands to generate substantial revenue. I don't fault them for that; I am "just saying" that they know between that funding and some monies coming due to mental health issues with mass shootings, there will be funds available to pay for treatment. If there had been money to be made before now, they would have already been on the bandwagon. Whatever the motivation, I am pleased to see some treatment options coming to the area to take the pressure off the Emergency Room and the state run facilities. It's long overdue.

Like · Reply · 1 · March 13 at 12:33am

Katie Hurst Ummm they aren't talking about expanding the hospital already there. This is for mental health ONLY!

Like · Reply · 2 · March 12 at 6:36pm

Bill Trewhitt We are lucky to have a hospital like Erlanger here.

Like · Reply · 13 · March 12 at 4:48pm

Kimberly Collier They killed my dad!!!!!! They need to evaluate their own mental health better yet hired experience surgeons.

Like · Reply · March 12 at 9:18pm

Vickie Steele I hope it's better than the Hosp. for sure.. I could have died up there.. such a non caring bunch!! I went by Ambulance & all they did was check my heart.. My BP was crazy & worst of all I was having Muscle spasms all over my body_Shaking- They gave me a muscle relaxer & sent me home.. Finally went to Park Ridge-They kept me for 2 Days until my Potassium was great..

Like · Reply · 5 · March 12 at 4:50pm

SUPPLEMENTAL #1

March 28, 2016
11:49 am

Katie Hurst That's why I request to be taken to Erlanger East or Parkridge East
Like · Reply · March 12 at 8:37pm · Edited

Karen Polcen I have had more problems with Erlanger & NEVER had a problem at Partridge Memorial.
Like · Reply · 1 · March 13 at 2:05pm

Write a reply...

Amy Dyer McCullough That's so right the world we Live in today puts alot of pressure on people causing mental problems. I had my daughter there and they treated me alright. Been a long time ago...
Like · Reply · 1 · March 12 at 5:06pm

Kellye Workman Stanley There cannot be enough mental health facilities in America.....let's think about the mass murders that occur that could possibly be prevented with proper treatment.
Like · Reply · 1 · March 12 at 9:26pm

Sharon Scarbrough Merrill We have 2 places, plus Geriatric mental health at Erlanger North.
Like · Reply · 1 · March 12 at 7:25pm

Wendy Grider Chattanooga already has Valley, Joe Johnson, & Moccasin Bend so why not bring some clinic that is needed in such as a cochlear clinic?
Like · Reply · 1 · March 12 at 8:28pm

Jodi Renfro Valley is a joke. If you have insurance joe Johnson is not an option. Moccassin Bend is for more criminal and severe mental health.
Like · Reply · 2 · March 12 at 9:08pm

Elicia Tallant Valley only takes people with insurance, moccasin bend only takes people who are committed by a dr, no voluntary... The wait times in ERs for a bed at Valley, MBMH, Valley West, pine ridge and Memphis is easily 60+ hours- that's 60 hours of a person in seclusion locked in a room bc there are no mental health beds available. This area does need another mental health facility- terribly
Like · Reply · 1 · March 13 at 12:25am

Wendy Grider Elicia Tallant we also need a cochlear clinic. Maybe you'd like to have to drive over 2 hrs each way for 1 appointment & have to buy gas & eat atleast 2 meals out. Another thing on days when patients have back to back appt's say 1 on Tuesday & 1 on Wednesday try over $100 for hotel room close to Vanderbilt since insurance won't cover that.
Like · Reply · March 13 at 9:22am

Write a reply...

Jaime Sanders This is so needed in our community! What a great resource it would be for so many who have minimal if any treatment options.
Like · Reply · 1 · March 12 at 6:28pm

Gretchen Gurley So many suffer from mental illness this will be great.
Like · Reply · 4 · March 12 at 4:53pm

Charlie Bradbury Great news! I don't like the location of erlanger's main campus, but this is still a needed facility.
Like · Reply · March 13 at 9:39am

Jodi Renfro Moccassin Bend is for more criminal or severely mental disabilities. I hope this goes thru. Parkridge Valley is horrible.
Like · Reply · 3 · March 12 at 5:16pm

Chris Limburg Thank you...you answered my question.
Like · Reply · 1 · March 12 at 8:05pm

SUPPLEMENTAL #1
172
March 28, 2016
11:49 am

Katie Hurst I'll be taking my son to it if they do therapy and med management. Rhea Mental Health is just not a place for kids therapy.

Like · Reply · March 12 at 8:38pm

Tabitha Sanders Katie Hurst Generations Mental Health Center across from McDonalds does therapy and med management in Rhea County

Like · Reply · March 12 at 8:44pm

Katie Hurst Thank you Tabitha Sanders. Rhea mental Health won't listen to me at all about my son. They gave him meds for something he didn't even have.

Like · Reply · March 13 at 9:30am

Write a reply...

Jessica Qualls This is has been needed for a long time. Mental healthcare in our area is in sad shape.

Like · Reply · 2 · March 12 at 5:40pm

Stephanie Coley Villalba Yes luv

Like · Reply · 1 · March 13 at 2:25pm

Write a reply...

Beverly Cooper I think they should, not enough coverage for those with behavioral problems in this area.

Like · Reply · 1 · March 13 at 8:24am

Alisha Michelle Chavez Erlanger is packed full of psych patients and they absolutely need this!

Like · Reply · 3 · March 12 at 5:37pm

Stacey Nicole Alvey I think this is the best idea I've heard in a long time!

Like · Reply · 2 · March 12 at 7:26pm

Melissa Wilbanks Bearden Mental health has sadly become a joke in our society. I'm super excited to see this happen.

Like · Reply · 1 · March 13 at 1:30pm

John-Christy Carroll-Southerland Melissa Boyd thought you think this was interesting.

Like · Reply · 1 · March 13 at 9:47am

Melissa Boyd Hopefully I will be finished with practitioners program by the time it is up and running.

Like · Reply · 1 · March 13 at 5:04pm

Write a reply...

Carol Garth Hixson This is a greatly needed facility. Beyond needed. Thank you.

Like · Reply · March 12 at 11:29pm

Melba Mitchell THE NEED IS IN CHICAGO !

Like · Reply · 1 · March 12 at 6:24pm

Chris Limburg Dont think there's much hope there...

Like · Reply · March 12 at 8:06pm

Write a reply...

Christopher Shawn Miller What about moccasin bend?

Like · Reply · 1 · March 12 at 5:09pm

Stephanie Coley Villalba More needs to be done than just the bend.

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Description	Section / Item
Letter Of Accreditation – *Joint Commission*	C-II-1

SUPPLEMENTAL #2
March 28, 2016
11:49 am

July 8, 2014

Re: #7809
CCN: #440104
Program: Hospital
Accreditation Expiration Date: April 05, 2017

Kevin M. Spiegel
President and CEO
Erlanger Health System
975 East Third Street
Chattanooga, Tennessee 37403

Dear Mr. Spiegel:

This letter confirms that your March 31, 2014 – April 04, 2014 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on June 20, 2014 and June 27, 2014 and the successful on-site Medicare Deficiency Follow-up event conducted on May 19, 2014, the areas of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of April 05, 2014. We congratulate you on your effective resolution of these deficiencies.

§482.12 Governing Body
§482.41 Physical Environment
§482.42 Infection Control

The Joint Commission is also recommending your organization for continued Medicare certification effective April 05, 2014. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following locations:

Academic Internal Medicine and Endocrinology
979 E. Third Street, Suite B-601, Chattanooga, TN, 37403

Academic Gastroenterology
979 East Third Street, Suite C-825, Chattanooga, TN, 37403

Academic Urologist at Erlanger
979 East Third Street, Suite C-535, Chattanooga, TN, 37403

Alton Park (Southside) Community Health Center
100 East 37th Street, Chattanooga, TN, 37410

Dodson Avenue Community Health Center
1200 Dodson Avenue, Chattanooga, TN, 37406

Erlanger Academic Urologists
1755 Gunbarrel Road, Suite 209, Chattanooga, TN, 37421

Erlanger at Volkswagon Drive Wellness Center
7380 Volkswagon Drive, Suite 110, Chattanooga, TN, 37416

Erlanger East Family Practice
1755 Gunbarrel Road, Suite 201, Chattanooga, TN, 37421

Erlanger East Imaging
1751 Gunbarrel Road, Chattanooga, TN, 37421

Erlanger Health System - East Campus
1751 Gunbarrel Road, Chattanooga, TN, 37421

Erlanger Health System - Main Site
975 East Third Street, Chattanooga, TN, 37403

Erlanger Health System - North Campus
632 Morrison Springs Road, Chattanooga, TN, 37415

Erlanger Hypertension Management Center
979 East Third Street, Suite B601, Chattanooga, TN, 37403

Erlanger Metabolic and Bariatric Surgery Center
979 E. Third Street Suite C-620, Chattanooga, TN, 37403

Erlanger Neurology/Southeast Regional Stroke Center
979 East Third Street, Suite C830, Chattanooga, TN, 37403

Erlanger North Family Practice, Neurobehavioral & Memory Svs
632 Morrison Springs Road, Suite 202, Chattanooga, TN, 37415

Erlanger North Sleep Medicine and Neurology
632 Morrison Springs Road, Suite 300, Chattanooga, TN, 37415

Erlanger South Family Practice
60 Erlanger Drive, Suite A, Ringgold, GA, 30736

Erlanger Specialty Care for OB and Peds
1504 North Thornton Avenue, Suite 104, Dalton, GA, 30720

Hypertension Management - Chattanooga Lifestyle Center
325 Market Street, Suite 200, Chattanooga, TN, 37401

Life Style Center - Cardiac Rehab
325 Market Street, Chattanooga, TN, 37401

Ortho South
979 East Third Street suite C-430, Chattanooga, TN, 37403

Southern Orthopaedic Trauma Surgeons
979 East Third Street Suite C-225, Chattanooga, TN, 37403

TCT Cardiology/GI/Genetics
910 Blackford Street - 3rd Fl Massoud, Chattanooga, TN, 37403

TCT Children's Subspecialty Center
2700 West Side Drive, Cleveland, TN, 37312

TCT Endocrine
910 Blackford, 1st fl Massoud, Chattanooga, TN, 37403

TCT Hematology/Oncology
910 Blackford Street - 5th fl Massoud Bl, Chattanooga, TN, 37403

TCT Nephrology
910 Blackford St, Ground Level, TCTCH, Chattanooga, TN, 37403

University Health Obstetrics & Gynecology
979 East Third Street, Suite C-725, Chattanooga, TN, 37403

University Medical Assoc
960 East Third Street, Whitehall Building, Suite 208, Chattanooga, TN, 37403

University Orthopedics
979 East Third Street, Suite C-220, Chattanooga, TN, 37403

University Pediatrics
910 Blackford Street - Gr floor Massoud, Chattanooga, TN, 37403

University Pulmonary and Critical Care
979 East Third Street, Suite C 735, Chattanooga, TN, 37403

University Rheumatology Associates
979 East Third Street, Suite B-805, Chattanooga, TN, 37403

UT Dermatology
979 East Third Street, - Suite 425 A - Med Mall, Chattanooga, TN, 37403

UT Erlanger Cardiology
975 East Third Street, Suite C-520, Chattanooga, TN, 37403

UT Erlanger Cardiology East
1614 Gunbarrel Road, Ste 101, Chattanooga, TN, 37421

Ut Erlanger Health & Wellness@Signal Mtn
2600 Taft Highway, Signal Mountain, TN, 37377

UT Erlanger Lookout Mtn Primary Care
100 McFarland Road, Lookout Mountain, GA, 30750

UT Erlanger Primary and Athletic Health
1200 Pineville Road, Chattanooga, TN, 37405

UT Family Practice
1100 East Third Street, Chattanooga, TN, 37403

Workforce at UT Family Practice
1100 East 3rd Street, Chattanooga, TN, 37403

We direct your attention to some important Joint Commission policies. First, your Medicare report is publicly accessible as required by the Joint Commission's agreement with the Centers for Medicare and Medicaid Services. Second, Joint Commission policy requires that you inform us of any changes in the name or ownership of your organization, or health care services you provide.

Sincerely,

Mark G. Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 4 /Survey and Certification Staff

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Description	Section / Item
Acadia SEC Form 10-K	C-III-10

SUPPLEMENTAL #1
March 28, 2016
11:49 am

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)

☒ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2015

or

☐ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from _____ to _____

Commission File Number: 001-35331

ACADIA HEALTHCARE COMPANY, INC.
(Exact Name of Registrant as Specified in Its Charter)

Delaware	45-2492228
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

6100 Tower Circle, Suite 1000
Franklin, Tennessee 37067
(Address, including zip code, of registrant's principal executive offices)

(615) 861-6000
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each Class	Name of exchange on which registered
Common Stock, $.01 par value	NASDAQ Global Select Market

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

SUPPLEMENTAL #1
March 28, 2016
11:49 am

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Acadia Healthcare Company, Inc.
Consolidated Balance Sheets

	December 31, 2015	December 31, 2014
	(In thousands, except share and per share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 11,215	$ 94,040
Accounts receivable, net of allowance for doubtful accounts of $29,332 and $22,449, respectively	216,626	118,378
Deferred tax assets	—	20,155
Other current assets	66,895	41,570
Total current assets	294,736	274,143
Property and equipment:		
Land	214,138	132,406
Building and improvements	1,277,800	858,055
Equipment	141,543	73,584
Construction in progress	195,042	66,268
Less accumulated depreciation	(119,470)	(60,613)
Property and equipment, net	1,709,053	1,069,700
Goodwill	2,128,215	802,986
Intangible assets, net	59,575	21,636
Deferred tax assets – noncurrent	49,114	13,141
Other assets	38,515	25,349
Total assets	$ 4,279,208	$ 2,206,955
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	$ 45,360	$ 26,965
Accounts payable	91,341	48,696
Accrued salaries and benefits	80,696	59,317
Other accrued liabilities	72,806	30,956
Total current liabilities	290,203	165,934
Long-term debt	2,195,384	1,052,670
Deferred tax liabilities – noncurrent	23,936	63,880
Other liabilities	78,602	43,506
Total liabilities	2,588,125	1,325,990
Redeemable noncontrolling interests	8,055	—
Equity:		
Preferred stock, $0.01 par value; 10,000,000 shares authorized, no shares issued	—	—
Common stock, $0.01 par value; 90,000,000 shares authorized; 70,745,746 and 59,211,859 issued and outstanding as of December 31, 2015 and 2014, respectively	707	592
Additional paid-in capital	1,572,972	847,301
Accumulated other comprehensive loss	(104,647)	(68,370)
Retained earnings	213,996	101,442
Total equity	1,683,028	880,965
Total liabilities and equity	$ 4,279,208	$ 2,206,955

See accompanying notes.

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Goodwill and Indefinite-Lived Intangible Assets

The Company's goodwill and other indefinite-lived intangible assets, which consist of licenses and accreditations and certificates of need intangible assets that are not amortized, are evaluated for impairment annually during the fourth quarter or more frequently if events indicate that the carrying value of a reporting unit may not be recoverable. The Company has two operating segments, U.S. Facilities and U.K. Facilities, for segment reporting purposes, each of which represents a reporting unit for purposes of the Company's goodwill impairment test. Potential impairment is noted for a reporting unit if its carrying value exceeds the fair value of the reporting unit. For a reporting unit with potential impairment of goodwill, the Company determines the implied fair value of goodwill. If the carrying value of goodwill exceeds its implied fair value, an impairment loss is recorded. The Company's annual impairment tests of goodwill and other indefinite-lived intangibles in 2015, 2014 and 2013 resulted in no impairment charges.

Other Current Assets

Other current assets consisted of the following (in thousands):

	As of December 31,	
	2015	2014
Prepaid expenses	$21,817	$11,746
Other receivables	17,518	12,713
Insurance receivable – current portion	5,290	3,500
Workers' compensation deposits – current portion	7,500	4,800
Income taxes receivable	6,540	3,399
Inventory	4,681	3,249
Other	3,549	2,163
Other current assets	$66,895	$41,570

Other Accrued Liabilities

Other accrued liabilities consisted of the following (in thousands):

	As of December 31,	
	2015	2014
Accrued interest	$26,132	$13,013
Insurance liability – current portion	10,490	4,239
Other current liabilities	7,499	725
Income taxes payable	7,367	148
Contingent consideration	667	3,000
Accrued property taxes	2,951	2,069
Other	17,700	7,762
Other accrued liabilities	$72,806	$30,956

Stock Compensation

The Company measures and recognizes the cost of employee services received in exchange for awards of equity instruments based on the grant-date fair value in accordance with Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") Topic 718, "*Compensation—Stock Compensation*." The Company uses the Black-Scholes valuation model to determine grant-date fair value for equity awards and uses straight-line amortization of share-based compensation expense over the requisite service period of the respective awards.

Earnings Per Share

Basic and diluted earnings per share are calculated in accordance with FASB ASC 260, "*Earnings Per Share*," based on the weighted-average number of shares outstanding in each period and dilutive stock options, non-vested shares and warrants, to the extent such securities have a dilutive effect on earnings per share.

SUPPLEMENTAL #1
March 28, 2016
11:49 am

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Acadia Healthcare Company, Inc.
Consolidated Statements of Income

	Year Ended December 31,		
	2015	2014	2013
	(In thousands, except per share amounts)		
Revenue before provision for doubtful accounts	$1,829,619	$1,030,784	$735,109
Provision for doubtful accounts	(35,127)	(26,183)	(21,701)
Revenue	1,794,492	1,004,601	713,408
Salaries, wages and benefits (including equity-based compensation expense of $20,472, $10,058 and $5,249, respectively)	973,732	575,412	407,962
Professional fees	116,463	52,482	37,171
Supplies	80,663	48,422	37,569
Rents and leases	32,528	12,201	10,049
Other operating expenses	206,746	110,654	80,572
Depreciation and amortization	63,550	32,667	17,090
Interest expense, net	106,742	48,221	37,250
Debt extinguishment costs	10,818	—	9,350
Loss (gain) on foreign currency derivatives	1,926	(15,262)	—
Transaction-related expenses	36,571	13,650	7,150
Total expenses	1,629,739	878,447	644,163
Income from continuing operations before income taxes	164,753	126,154	69,245
Provision for income taxes	53,388	42,922	25,975
Income from continuing operations	111,365	83,232	43,270
Income (loss) from discontinued operations, net of income taxes	111	(192)	(691)
Net income	111,476	83,040	42,579
Net loss attributable to noncontrolling interests	1,078	—	—
Net income attributable to Acadia Healthcare Company, Inc.	$ 112,554	$ 83,040	$ 42,579
Basic earnings attributable to Acadia Healthcare Company, Inc. stockholders:			
Income from continuing operations	$ 1.65	$ 1.51	$ 0.87
Loss from discontinued operations	—	—	(0.02)
Net income	$ 1.65	$ 1.51	$ 0.85
Diluted earnings attributable to Acadia Healthcare Company, Inc. stockholders:			
Income from continuing operations	$ 1.64	$ 1.50	$ 0.86
Loss from discontinued operations	—	—	(0.01)
Net income	$ 1.64	$ 1.50	$ 0.85
Weighted-average shares outstanding:			
Basic	68,085	55,063	50,004
Diluted	68,391	55,327	50,261

See accompanying notes.

SUPPLEMENTAL #1
March 28, 2016
11:49 am

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Acadia Healthcare Company, Inc.
Consolidated Statements of Comprehensive Income

	Year Ended December 31,		
	2015	2014	2013
		(In thousands)	
Net income	$111,476	$ 83,040	$42,579
Other comprehensive loss:			
Foreign currency translation loss	(40,103)	(66,206)	—
Pension liability adjustment, net of tax of $0.9 million, $0.6 and $0, respectively	3,826	(2,164)	—
Other comprehensive loss	(36,277)	(68,370)	—
Comprehensive loss	75,199	14,670	42,579
Comprehensive loss attributable to noncontrolling interests	1,078	—	—
Comprehensive (loss) income attributable to Acadia Healthcare Company. Inc.	$ 76,277	$ 14,670	$42,579

See accompanying notes.

SUPPLEMENTAL #1
March 28, 2016
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Acadia Healthcare Company, Inc.
Consolidated Statements of Equity

	Common Stock		Additional Paid-in Capital	Other Comprehensive Loss	Retained Earnings (Accumulated Deficit)	Total
	Shares	Amount				
Balance at January 1, 2013	49,887	$ 499	$ 456,228	$ —	$ (24,177)	$ 432,550
Common stock issued under stock incentive plans	184	2	311	—	—	313
Common stock withheld for minimum statutory taxes	—	—	(1,555)	—	—	(1,555)
Equity-based compensation expense	—	—	5,249	—	—	5,249
Excess tax benefit from equity awards	—	—	1,779	—	—	1,779
Issuance of common stock, net	—	—	(205)	—	—	(205)
Net income	—	—	—	—	42,579	42,579
Balance at December 31, 2013	50,071	$ 501	$ 461,807	$ —	$ 18,402	$ 480,710
Common stock issued under stock incentive plans	259	2	568	—	—	570
Common stock withheld for minimum statutory taxes	—	—	(4,669)	—	—	(4,669)
Equity-based compensation expense	—	—	10,058	—	—	10,058
Excess tax benefit from equity awards	—	—	4,617	—	—	4,617
Issuance of common stock, net	8,882	89	374,342	—	—	374,431
Other	—	—	578	—	—	578
Other comprehensive loss	—	—	—	(68,370)	—	(68,370)
Net income	—	—	—	—	83,040	83,040
Balance at December 31, 2014	59,212	$ 592	$ 847,301	$ (68,370)	$ 101,442	$ 880,965
Common stock issued under stock incentive plans	384	4	1,811	—	—	1,815
Common stock withheld for minimum statutory taxes	—	—	(9,577)	—	—	(9,577)
Equity-based compensation expense	—	—	20,472	—	—	20,472
Excess tax benefit from equity awards	—	—	309	—	—	309
Issuance of common stock, net	11,150	111	711,406	—	—	711,517
Other comprehensive loss	—	—	—	(36,277)	—	(36,277)
Other	—	—	1,250	—	—	1,250
Net income attributable to Acadia Healthcare Company, Inc. stockholders	—	—	—	—	112,554	112,554
Balance at December 31, 2015	70,746	$ 707	$1,572,972	$ (104,647)	$ 213,996	$1,683,028

See accompanying notes.

SUPPLEMENTAL #1
March 28, 2016
11:49 am

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Acadia Healthcare Company, Inc.
Consolidated Statements of Cash Flows

	Year Ended December 31,		
	2015	2014	2013
	(In thousands)		
Operating activities:			
Net income	$ 111,476	$ 83,040	$ 42,579
Adjustments to reconcile net income to net cash provided by continuing operating activities:			
Depreciation and amortization	63,550	32,667	17,090
Amortization of debt issuance costs	6,709	3,198	2,264
Equity-based compensation expense	20,472	10,058	5,249
Deferred income tax expense	43,613	7,215	10,083
(Income) loss from discontinued operations, net of taxes	(111)	192	691
Debt extinguishment costs	10,818	—	9,350
Loss (gain) on foreign currency derivatives	1,926	(15,262)	—
Other	1,615	488	21
Change in operating assets and liabilities, net of effect of acquisitions:			
Accounts receivable, net	(24,954)	(15,110)	(21,242)
Other current assets	(2,717)	(2,011)	(3,652)
Other assets	(8,021)	(6,513)	(2,239)
Accounts payable and other accrued liabilities	6,868	2,793	(848)
Accrued salaries and benefits	1,658	11,980	2,803
Other liabilities	9,236	2,749	3,181
Net cash provided by continuing operating activities	242,138	115,484	65,330
Net cash (used in) provided by discontinued operating activities	(1,735)	(198)	232
Net cash provided by operating activities	240,403	115,286	65,562
Investing activities:			
Cash paid for acquisitions, net of cash acquired	(574,777)	(738,702)	(164,019)
Cash paid for capital expenditures	(276,047)	(113,244)	(68,941)
Cash paid for real estate acquisitions	(26,622)	(23,177)	(8,092)
Settlement of foreign currency derivatives	(1,926)	15,262	—
Other	(5,099)	(913)	(1,926)
Net cash used in investing activities	(884,471)	(860,774)	(242,978)
Financing activities:			
Borrowings on long-term debt	1,150,000	542,500	150,000
Borrowings on revolving credit facility	468,000	230,500	61,500
Principal payments on revolving credit facility	(310,000)	(284,000)	(8,000)
Principal payments on long-term debt	(31,965)	(7,695)	(7,680)
Repayment of assumed CRC debt	(904,467)	—	—
Repayment of senior notes	(97,500)	—	(52,500)
Payment of debt issuance costs	(26,421)	(12,993)	(4,307)
Payment of premium on senior notes	(7,480)	—	(6,759)
Issuances of common stock, net	331,308	374,431	(205)
Common stock withheld for minimum statutory taxes, net	(7,762)	(4,099)	(1,242)
Excess tax benefit from equity awards	309	4,617	1,779
Cash paid for contingent consideration	—	(5,000)	—
Other	(420)	(289)	—
Net cash provided by financing activities	563,602	837,972	132,586
Effect of exchange rate changes on cash	(2,359)	(3,013)	—
Net increase(decrease) in cash and cash equivalents	(82,825)	89,471	(44,830)
Cash and cash equivalents at beginning of the period	94,040	4,569	49,399
Cash and cash equivalents at end of the period	$ 11,215	$ 94,040	$ 4,569

(continued on next page)

SUPPLEMENTAL #1
March 28, 2016
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Acadia Healthcare Company, Inc.
Consolidated Statements of Cash Flows (continued)

	Year Ended December 31,		
	2015	2014	2013
	(In thousands)		
Supplemental Cash Flow Information:			
Cash paid for interest	$ 87,034	$ 36,776	$ 33,270
Cash paid for income taxes	$ 6,911	$ 32,257	$ 16,960
Significant Non-Cash Transactions:			
Contingent consideration issued in connection with acquisition	$ —	$ 1,467	$ —
Effect of acquisitions:			
Assets acquired, excluding cash	$ 1,988,634	$819,518	$192,928
Liabilities assumed	(1,024,515)	(78,849)	(17,725)
Issuance of common stock in connection with acquisition	(380,210)	—	—
Redeemable noncontrolling interest resulting from acquisitions	(9,132)	—	—
Deposits paid for acquisitions	—	—	500
Prior year deposits paid for acquisitions	—	(500)	(11,684)
Contingent consideration issued in connection with acquisition	—	(1,467)	—
Cash paid for acquisitions, net of cash acquired	$ 574,777	$738,702	$164,019

See accompanying notes.

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Acadia Healthcare Company, Inc.
Condensed Consolidating Balance Sheets
December 31, 2015
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Current assets:					
Cash and cash equivalents	$ —	$ 1,987	$ 9,228	$ —	$ 11,215
Accounts receivable, net	—	187,546	29,080	—	216,626
Deferred tax assets	—	—	—	—	—
Other current assets	—	57,968	8,927	—	66,895
Total current assets	—	247,501	47,235	—	294,736
Property and equipment, net	—	805,439	903,614	—	1,709,053
Goodwill	—	1,835,339	292,876	—	2,128,215
Intangible assets, net	—	57,024	2,551	—	59,575
Deferred tax assets – noncurrent	3,946	40,587	4,581	—	49,114
Investment in subsidiaries	1,323,069	—	—	(1,323,069)	—
Other assets	427,270	32,947	2,322	(424,024)	38,515
Total assets	$1,754,285	$3,018,837	$1,253,179	$(1,747,093)	$4,279,208
Current liabilities:					
Current portion of long-term debt	$ 45,125	$ —	$ 235	$ —	$ 45,360
Accounts payable	—	75,015	16,326	—	91,341
Accrued salaries and benefits	—	66,249	14,447	—	80,696
Other accrued liabilities	26,132	10,886	35,788	—	72,806
Total current liabilities	71,257	152,150	66,796	—	290,203
Long-term debt	—	2,171,998	447,410	(424,024)	2,195,384
Deferred tax liabilities – noncurrent	—	—	23,936	—	23,936
Other liabilities	—	75,159	3,443	—	78,602
Total liabilities	71,257	2,399,307	541,585	—	2,588,125
Redeemable noncontrolling interests	—	—	8,055	—	8,055
Total equity	1,683,028	619,530	703,539	(1,323,069)	1,683,028
Total liabilities and equity	$1,754,285	$3,018,837	$1,253,179	$(1,747,093)	$4,279,208

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Acadia Healthcare Company, Inc.
Condensed Consolidating Balance Sheets
December 31, 2014
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Current assets:					
Cash and cash equivalents	$ —	$ 76,685	$ 17,355	$ —	$ 94,040
Accounts receivable, net	—	100,797	17,581	—	118,378
Deferred tax assets	—	18,395	1,760	—	20,155
Other current assets	—	36,049	5,521	—	41,570
Total current assets	—	231,926	42,217	—	274,143
Property and equipment, net	—	451,943	617,757	—	1,069,700
Goodwill	—	596,611	206,375	—	802,986
Intangible assets, net	—	19,057	2,579	—	21,636
Deferred tax assets – noncurrent	4,563	—	14,244	(5,666)	13,141
Investment in subsidiaries	1,759,337	—	—	(1,759,337)	—
Other assets	186,073	18,727	2,323	(181,774)	25,349
Total assets	$1,949,973	$1,318,264	$ 885,495	$(1,946,777)	$2,206,955
Current liabilities:					
Current portion of long-term debt	$ 26,750	$ —	$ 215	$ —	$ 26,965
Accounts payable	—	39,486	9,210	—	48,696
Accrued salaries and benefits	—	47,597	11,720	—	59,317
Other accrued liabilities	13,647	7,688	9,621	—	30,956
Total current liabilities	40,397	94,771	30,766	—	165,934
Long-term debt	1,028,611	—	205,833	(181,774)	1,052,670
Deferred tax liabilities – noncurrent	—	21,027	48,519	(5,666)	63,880
Other liabilities	—	33,321	10,185	—	43,506
Total liabilities	1,069,008	149,119	295,303	(187,440)	1,325,990
Total equity	880,965	1,169,145	590,192	(1,759,337)	880,965
Total liabilities and equity	$1,949,973	$1,318,264	$ 885,495	$(1,946,777)	$2,206,955

SUPPLEMENTAL #1
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Acadia Healthcare Company, Inc.
Condensed Consolidating Statement of Comprehensive Income
Year Ended December 31, 2015
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Revenue before provision for doubtful accounts	$ —	$1,415,016	$ 414,603	$ —	$1,829,619
Provision for doubtful accounts	—	(32,614)	(2,513)	—	(35,127)
Revenue	—	1,382,402	412,090	—	1,794,492
Salaries, wages and benefits	20,472	726,215	227,045	—	973,732
Professional fees	—	83,422	33,041	—	116,463
Supplies	—	65,077	15,586	—	80,663
Rents and leases	—	29,094	3,434	—	32,528
Other operating expenses	—	170,018	36,728	—	206,746
Depreciation and amortization	—	41,768	21,782	—	63,550
Interest expense, net	68,533	17,476	20,733	—	106,742
Debt extinguishment costs	10,818	—	—	—	10,818
Loss on foreign currency derivatives	1,926	—	—	—	1,926
Transaction-related expenses	—	24,914	11,657	—	36,571
Total expenses	101,749	1,157,984	370,006	—	1,629,739
(Loss) income from continuing operations before income taxes	(101,749)	224,418	42,084	—	164,753
Equity in earnings of subsidiaries	176,178	—	—	(176,178)	—
(Benefit from) provision for income taxes	(37,047)	85,765	4,670	—	53,388
Income (loss) from continuing operations	111,476	138,653	37,414	(176,178)	111,365
Income from discontinued operations, net of income taxes	—	111	—	—	111
Net income (loss)	111,476	138,764	37,414	(176,178)	111,476
Net loss attributable to noncontrolling interests	—	—	1,078	—	1,078
Net income attributable to Acadia Healthcare Company, Inc.	$ 111,476	$ 138,764	$ 38,492	$ (176,178)	$ 112,554
Other comprehensive income:					
Foreign currency translation gain	—	—	(40,103)	—	(40,103)
Pension liability adjustment, net	—	—	3,826	—	3,826
Other comprehensive income	—	—	(36,277)	—	(36,277)
Comprehensive income (loss)	$ 111,476	$ 138,764	$ 2,215	$ (176,178)	$ 76,277

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Acadia Healthcare Company, Inc.
Condensed Consolidating Statement of Comprehensive Income
Year Ended December 31, 2014
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Revenue before provision for doubtful accounts	$ —	$ 826,465	$ 204,319	$ —	$1,030,784
Provision for doubtful accounts	—	(23,866)	(2,317)	—	(26,183)
Revenue	—	802,599	202,002	—	1,004,601
Salaries, wages and benefits	10,058	459,297	106,057	—	575,412
Professional fees	—	38,632	13,850	—	52,482
Supplies	—	40,511	7,911	—	48,422
Rents and leases	—	10,136	2,065	—	12,201
Other operating expenses	—	83,835	26,819	—	110,654
Depreciation and amortization	—	22,990	9,677	—	32,667
Interest expense, net	27,199	6,207	14,815	—	48,221
Gain on foreign currency derivatives	(15,262)	—	—	—	(15,262)
Transaction-related expenses	—	12,367	1,283	—	13,650
Total expenses	21,995	673,975	182,477	—	878,447
(Loss) income from continuing operations before income taxes	(21,995)	128,624	19,525	—	126,154
Equity in earnings of subsidiaries	97,414	—	—	(97,414)	—
(Benefit from) provision for income taxes	(7,621)	44,608	5,935	—	42,922
Income (loss) from continuing operations	83,040	84,016	13,590	(97,414)	83,232
Loss from discontinued operations, net of income taxes	—	(192)	—	—	(192)
Net income (loss)	$ 83,040	$ 83,824	$ 13,590	$ (97,414)	$ 83,040
Other comprehensive loss:					
Foreign currency translation loss	—	—	(66,206)	—	(66,206)
Pension liability adjustment, net	—	—	(2,164)	—	(2,164)
Other comprehensive loss	—	—	(68,370)	—	(68,370)
Comprehensive income (loss)	$ 83,040	$ 83,824	$ (54,780)	$ (97,414)	$ 14,670

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Acadia Healthcare Company, Inc.
Condensed Consolidating Statement of Comprehensive Income
Year Ended December 31, 2013
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Revenue before provision for doubtful accounts	$ —	$ 700,407	$ 34,702	$ —	$ 735,109
Provision for doubtful accounts	—	(20,700)	(1,001)	—	(21,701)
Revenue	—	679,707	33,701	—	713,408
Salaries, wages and benefits	5,249	388,749	13,964	—	407,962
Professional fees	—	34,149	3,022	—	37,171
Supplies	—	35,686	1,883	—	37,569
Rents and leases	—	9,282	767	—	10,049
Other operating expenses	—	72,626	7,946	—	80,572
Depreciation and amortization	—	15,882	1,208	—	17,090
Interest expense, net	35,327	22	1,901	—	37,250
Debt extinguishment costs	9,350	—	—	—	9,350
Transaction-related expenses	—	6,716	434	—	7,150
Total expenses	49,926	563,112	31,125	—	644,163
(Loss) income from continuing operations before income taxes	(49,926)	116,595	2,576	—	69,245
Equity in earnings of subsidiaries	73,538	—	—	(73,538)	—
(Benefit from) provision for income taxes	(18,967)	44,294	648	—	25,975
Income (loss) from continuing operations	42,579	72,301	1,928	(73,538)	43,270
Loss from discontinued operations, net of income taxes	—	(691)	—	—	(691)
Net income (loss)	$ 42,579	$ 71,610	$ 1,928	$ (73,538)	$ 42,579
Comprehensive income (loss)	$ 42,579	$ 71,610	$ 1,928	$ (73,538)	$ 42,579

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Acadia Healthcare Company, Inc.
Condensed Consolidating Statement of Cash Flows
Year Ended December 31, 2015
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Operating activities:					
Net income (loss)	$ 111,476	$ 138,764	$ 37,414	$ (176,178)	$ 111,476
Adjustments to reconcile net income (loss) to net cash (used in) provided by continuing operating activities:					
Equity in earnings of subsidiaries	(176,178)	—	—	176,178	—
Depreciation and amortization	—	41,768	21,782	—	63,550
Amortization of debt issuance costs	7,147	—	(438)	—	6,709
Equity-based compensation expense	20,472	—	—	—	20,472
Deferred income tax (benefit) expense	617	42,246	750	—	43,613
Loss from discontinued operations, net of taxes	—	(111)	—	—	(111)
Debt extinguishment costs	10,818	—	—	—	10,818
Loss (gain) on foreign currency derivatives	1,926	—	—	—	1,926
Other	—	1,582	33	—	1,615
Change in operating assets and liabilities, net of effect of acquisitions:					
Accounts receivable, net	—	(18,632)	(6,322)	—	(24,954)
Other current assets	—	(1,152)	(1,565)	—	(2,717)
Other assets	(1,100)	(8,567)	546	1,100	(8,021)
Accounts payable and other accrued liabilities	—	(7,583)	14,451	—	6,868
Accrued salaries and benefits	—	312	1,346	—	1,658
Other liabilities	—	9,350	(114)	—	9,236
Net cash (used in) provided by continuing operating activities	(24,822)	197,977	67,883	1,100	242,138
Net cash provided by discontinued operating activities	—	(1,735)	—	—	(1,735)
Net cash (used in) provided by operating activities	(24,822)	196,242	67,883	1,100	240,403
Investing activities:					
Cash paid for acquisitions, net of cash acquired	—	(254,848)	(319,929)	—	(574,777)
Cash paid for capital expenditures	—	(172,329)	(103,718)	—	(276,047)
Cash paid for real estate acquisitions	—	(25,293)	(1,329)	—	(26,622)
Settlement of foreign currency derivatives	—	(1,926)	—	—	(1,926)
Other	—	(5,099)	—	—	(5,099)
Net cash used in investing activities	—	(459,495)	(424,976)	—	(884,471)
Financing activities:					
Borrowings on long-term debt	1,150,000	—	—	—	1,150,000
Borrowings on revolving credit facility	468,000	—	—	—	468,000
Principal payments on revolving credit facility	(310,000)	—	—	—	(310,000)
Principal payments on long-term debt	(31,965)	—	(1,315)	1,315	(31,965)
Repayment of assumed CRC debt	(904,467)	—	—	—	(904,467)
Repayments of senior notes	(97,500)	—	—	—	(97,500)
Payment of debt issuance costs	(26,421)	—	—	—	(26,421)
Payment of premium on senior notes	(7,480)	—	—	—	(7,480)
Issuance of Common Stock	—	331,308	—	—	331,308
Common stock withheld for minimum statutory taxes, net	(7,762)	—	—	—	(7,762)
Excess tax benefit from equity awards	309	—	—	—	309
Other	—	(420)	—	—	(420)
Cash provided by (used in) intercompany activity	(207,892)	(139,974)	350,281	(2,415)	—
Net cash provided by (used in) financing activities	24,822	190,914	348,966	(1,100)	563,602
Effect of exchange rate changes on cash	—	(2,359)	—	—	(2,359)
Net (decrease) increase in cash and cash equivalents	—	(74,698)	(8,217)	—	(82,825)
Cash and cash equivalents at beginning of the period	—	76,685	17,355	—	94,040
Cash and cash equivalents at end of the period	$ —	$ 1,987	$ 9,228	$ —	$ 11,215

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Acadia Healthcare Company, Inc.
Condensed Consolidating Statement of Cash Flows
Year Ended December 31, 2014
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Operating activities:					
Net income (loss)	$ 83,040	$ 83,824	$ 13,590	$ (97,414)	$ 83,040
Adjustments to reconcile net income (loss) to net cash (used in) provided by continuing operating activities:					
Equity in earnings of subsidiaries	(97,414)	—	—	97,414	—
Depreciation and amortization	—	22,990	9,677	—	32,667
Amortization of debt issuance costs	2,748	—	450	—	3,198
Equity-based compensation expense	10,058	—	—	—	10,058
Deferred income tax (benefit) expense	(1,969)	5,231	3,953	—	7,215
Loss from discontinued operations, net of taxes	—	192	—	—	192
Gain on foreign currency derivatives	(15,262)	—	—	—	(15,262)
Other	—	449	39	—	488
Change in operating assets and liabilities, net of effect of acquisitions:					
Accounts receivable, net	—	(13,636)	(1,474)	—	(15,110)
Other current assets	—	(2,205)	194	—	(2,011)
Other assets	(1,151)	(6,910)	397	1,151	(6,513)
Accounts payable and other accrued liabilities	—	(5,559)	8,352	—	2,793
Accrued salaries and benefits	—	11,035	945	—	11,980
Other liabilities	—	1,769	980	—	2,749
Net cash (used in) provided by continuing operating activities	(19,950)	97,180	37,103	1,151	115,484
Net cash used in discontinued operating activities	—	(198)	—	—	(198)
Net cash (used in) provided by operating activities	(19,950)	96,982	37,103	1,151	115,286
Investing activities:					
Cash paid for acquisitions, net of cash acquired	—	(723,064)	(15,638)	—	(738,702)
Cash paid for capital expenditures	—	(83,864)	(29,380)	—	(113,244)
Cash paid for real estate acquisitions	—	(23,177)	—	—	(23,177)
Settlement of foreign currency derivatives	15,262	—	—	—	15,262
Other	—	(913)	—	—	(913)
Net cash used in investing activities	15,262	(831,018)	(45,018)	—	(860,774)
Financing activities:					
Borrowings on long-term debt	542,500	—	—	—	542,500
Borrowings on revolving credit facility	230,500	—	—	—	230,500
Principal payments on revolving credit facility	(284,000)	—	—	—	(284,000)
Principal payments on long-term debt	(7,500)	—	(1,346)	1,151	(7,695)
Payment of debt issuance costs	(12,993)	—	—	—	(12,993)
Issuance of common stock, net	374,431	—	—	—	374,431
Common stock withheld for minimum statutory taxes, net	(4,099)	—	—	—	(4,099)
Excess tax benefit from equity awards	4,617	—	—	—	4,617
Cash paid for contingent consideration	—	(5,000)	—	—	(5,000)
Other	—	(289)	—	—	(289)
Cash (used in) provided by intercompany activity	(838,768)	816,010	23,135	(377)	—
Net cash provided by financing activities	4,688	810,721	21,789	774	837,972
Effect of exchange rate changes on cash	—	—	(3,013)	—	(3,013)
Net increase in cash and cash equivalents	—	76,685	10,861	1,925	89,471
Cash and cash equivalents at beginning of the period	—	—	6,494	(1,925)	4,569
Cash and cash equivalents at end of the period	$ —	$ 76,685	$ 17,355	$ —	$ 94,040

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Acadia Healthcare Company, Inc.
Condensed Consolidating Statement of Cash Flows
Year Ended December 31, 2013
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Operating activities:					
Net income (loss)	$ 42,579	$ 71,610	$ 1,928	$ (73,538)	$ 42,579
Adjustments to reconcile net income (loss) to net cash (used in) provided by continuing operating activities:					
Equity in earnings of subsidiaries	(73,538)	—	—	73,538	—
Depreciation and amortization	—	15,882	1,208	—	17,090
Amortization of debt issuance costs	2,725	—	(461)	—	2,264
Equity-based compensation expense	5,249	—	—	—	5,249
Deferred income tax expense	(754)	10,278	559	—	10,083
Loss from discontinued operations, net of taxes	—	691	—	—	691
Debt extinguishment costs	9,350	—	—	—	9,350
Other	—	21	—	—	21
Change in operating assets and liabilities, net of effect of acquisitions:					
Accounts receivable, net	—	(22,768)	1,526	—	(21,242)
Other current assets	—	(3,774)	122	—	(3,652)
Other assets	—	(1,950)	(289)	—	(2,239)
Accounts payable and other accrued liabilities	—	(287)	(561)	—	(848)
Accrued salaries and benefits	—	2,161	642	—	2,803
Other liabilities	—	3,181	—	—	3,181
Net cash (used in) provided by continuing operating activities	(14,389)	75,045	4,674	—	65,330
Net cash used in discontinued operating activities	—	232	—	—	232
Net cash (used in) provided by operating activities	(14,389)	75,277	4,674	—	65,562
Investing activities:					
Cash paid for acquisitions, net of cash acquired	—	(164,019)	—	—	(164,019)
Cash paid for capital expenditures	—	(68,497)	(444)	—	(68,941)
Cash paid for real estate acquisitions	—	(8,092)	—	—	(8,092)
Other	—	(1,926)	—	—	(1,926)
Net cash used in investing activities	—	(242,534)	(444)	—	(242,978)
Financing activities:					
Borrowings on long-term debt	150,000	—	—	—	150,000
Borrowings on revolving credit facility	61,500	—	—	—	61,500
Principal payments on revolving credit facility	(8,000)	—	—	—	(8,000)
Principal payments on long-term debt	(7,500)	—	(180)	—	(7,680)
Repayment of long-term debt	(52,500)	—	—	—	(52,500)
Payment of debt issuance costs	(4,307)	—	—	—	(4,307)
Payment of premium on note redemption	(6,759)	—	—	—	(6,759)
Issuance of common stock, net	(205)	—	—	—	(205)
Common stock withheld for minimum statutory taxes, net	(1,242)	—	—	—	(1,242)
Excess tax benefit from equity awards	1,779	—	—	—	1,779
Cash (used in) provided by intercompany activity	(118,377)	117,950	2,352	(1,925)	—
Net cash (used in) provided by financing activities	14,389	117,950	2,172	(1,925)	132,586
Net (decrease) increase in cash and cash equivalents	—	(49,307)	6,402	(1,925)	(44,830)
Cash and cash equivalents at beginning of the period	—	49,307	92	—	49,399
Cash and cash equivalents at end of the period	$ —	$ —	$ 6,494	$ (1,925)	$ 4,569

Supplemental #2
-COPY-

Erlanger Behavioral Health, LLC.

CN1603-012

SUPPLEMENTAL INFORMATION (No. 2)

Erlanger Behavioral Health, LLC

Application To Initiate Psychiatric Services At The Intersection Of North Holtzclaw Avenue And Citico Avenue, In Chattanooga, Tennessee, With Establishment Of An Eighty-Eight (88) Bed Inpatient Hospital By The Addition Of Seventy-Six (76) Psychiatric Beds And The Transfer Of Twelve (12) Geriatric-Psychiatric Beds From *Erlanger North Hospital*

Application Number CN1603-012

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

Supplemental Responses To Questions Of The Tennessee Health Services & Development Agency

1.) Section A, Applicant Profile, Item 6.

The *Letter of Agreement* between *Erlanger Health System* and *Acadia Healthcare* dated February 16, 2016, regarding the potential venture is noted. However, the document cites an 80 bed hospital rather than an 88 bed hospital as indicated in the applicant's letter of intent. Please revise.

Response

A copy of the *Letter of Agreement* between *Erlanger Health System* and *Acadia Healthcare* was provided with the first supplement to this CON application. In the *Letter of Agreement*, Section 4, Item b(2), it states that CON approval for a facility "for at least 80 psychiatric beds" … therefore, it may be seen that the parties contemplated a *minimum* number of 80 beds. The possibility of additional beds was known to be likely given the significant need for behavioral health services in the defined service area.

2.) Section B, Project Description, Item 1.

What type of outpatient, intensive outpatient, and partial hospitalization programs are associated with this project?

Response

Erlanger Behavioral Health will offer three levels of outpatient care to include outpatient programs and consultation, intensive outpatient programs and partial hospitalization programs.

Outpatient programs to be provided will be tailored to fit the patient's needs and diagnosis, but could include couples and family therapy, child or adolescent therapy, cognitive therapy, etc. The therapy program would follow an assessment of the individuals functioning including physical, psychological, social, educational, etc. and related challenges. Services would also include behavioral medicine provided to patients impacted by comorbid medical

conditions, such as cardiac, obstetrics, cancer, bariatrics, etc.

The intensive outpatient programs (IOP) to be provided will also be customized to individual patients but will typically be provided in group with 10 or less patients, though each patient would also be assigned and individual therapist. Common programing would include sessions on relapse prevention, urges and cravings, chemistry of addiction, stages of change and family education, as applicable. The IOP will be for persons struggling with problems associated with addictions, substance abuse, abuse and comorbidities associates with substance use, depression, schizophrenia, bipolar disorders, etc.

The partial hospitalization program will also be tailored to the individual patient but will be provided in groups to allow patients to interact with others experiencing similar problems. The program will be structured to serve as an alternative to inpatient care. The program will be more intense than care provided in the outpatient or intensive outpatient programs. Patient served will be those that are experiencing acute psychiatric symptoms that are difficult to manage but that do not require 24-hour care. Patients in the partial hospitalization program will attend structured programming throughout the day, three to five days a week and return home in the evenings. Patients will interact with psychiatrists, social workers, nurses, and other mental health practitioners.

The goal of the partial program will be to help the patient manage their lives and symptoms. Persons served in the partial hospitalization program will be those who do not pose an immediate risk to themselves or others. Services are provided for the purpose of active treatment of a person's condition to prevent relapse, hospitalization, or incarceration. The program functions as an alternative to inpatient care, as transitional care following an inpatient stay in lieu of continued hospitalization, as a step-down service, or when the severity of symptoms is such that success in a less acute outpatient setting is not likely to be effective.

3.) Section C, Need, Item 1.a (Project Specific Criteria-Psychiatric Inpatient Services A.Need, 1).

Please revise pages 32-41 which reflects the current Guidelines for Growth Standards for Psychiatric Inpatient Services according to the following:

- **It is noted the current Guidelines for Growth do not take into account population and inpatient mental health beds outside of the State of Tennessee in determining psychiatric bed need. Please revise.**

- **The population data source of Claritas has been used to determine the bed need in the proposed service area. However, the Claritas 2016 population for the proposed Tennessee service area is 992,666 which is 6.6% greater than the Tennessee Department of Health's 2016 population of 930,858 as noted in the table on page 47 of the original application. Please adjust and revise all population statistics in determining need according to the Tennessee Department of Health statistics.**

- **The inclusion of Moccasin Bend Mental Health Institute's licensed beds in the bed calculations on page 33 and in the tables and narrative response on page 34 is noted. However, the applicant incorrectly assigned Moccasin Bend Mental Health Institute's 150 licensed beds to Parkridge West Hospital-Jasper, Tennessee in the chart listing total psych/substance beds for the service area. Please include the revision in the replacement for page 35.**

- **The applicant submitted 36R which did not correspond and flow with the original application pages 36-37 and omitted information that was included in the original application. When pages 32-43 are revised and submitted, please pay particular attention that each page flows from one to the next.**

Response

The replacement pages for 32-41 of the CON application have been revised appropriately to present the Tennessee portion of the service area, and then the non-Tennessee

portion of the service area is presented in a separate table. The combined net bed need is discussed for the entire service area.

The population estimates for the Tennessee portion of the service area have been adjusted to reflect the estimates by the Tennessee Dept. of Health.

As requested, a correction to the table to accurately reflect *Moccasin Bend Mental Health Institute* has been made to the table of currently licensed psychiatric beds.

4.) Section C, Economic Feasibility, Item 2 (Funding) & Item 10.

It is noted Acadia will not finance a portion of the proposed project with a revolving line of credit, but with cash reserves. However, it is noted the Acadia Healthcare Company, Inc., Consolidated Balance Sheet for the period ending December 31, 2015 reflected total current assets of $294,143,000 and current liabilities of $290,203,000 which calculates to a current ratio of 1.01 to 1. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities. According to this ratio formula, it appears Acadia does not have adequate current liquidity or reserves to appropriately fund the proposed project. Please clarify.

It is noted the February 16, 2016 Joint Venture Letter of Intent indicates funding for construction of the proposed project is conditioned on 4 stage two obligations. If any of those obligations are not met, is Erlanger Health System prepared and able to fund the proposed project alone? If so, please provide the documentation.

Response

Acadia Healthcare has advised that they have a $ 300 million credit line available to fund the project. Interest on the credit line is retained at the *Acadia* corporate level. *Acadia* will contribute cash to the JV to fund development costs so no interest expense is chargeable to the project. Please see the letter from *Acadia* attached to this supplemental information.

Concerning whether the stage two obligations are not met by *Acadia*, *Erlanger Health System* has the patients and funds to develop and implement the project. However, *Erlanger* would seek another partner in the event *Acadia* is unable to execute as contemplated.

SUPPLEMENTAL #2
March 31, 2016
11:59 am

A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger Behavioral Health, LLC

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 30th of March (Month), 2016 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

ELIZABETH JONES
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

NOTARY PUBLIC

My commission expires August 8 (Month / Day), 2018.

SUPPLEMENTAL #2
March 31, 2016
11:59 am

TABLE OF ATTACHMENTS

SUPPLEMENTAL #2
March 31, 2016
11:59 am

Description	Section / Item
Letter From *Acadia Healthcare* CFO	
CON Replacement Pages	

ATTACHMENTS

ACADIA
HEALTHCARE

March 30, 2016

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Frost Building, Third Floor
161 Rosa Parks Boulevard
Nashville, Tennessee 37203

RE: Financing Commitment
Erlanger Behavioral Health, LLC
Hamilton County

Dear Mrs. Hill:

Erlanger Behavioral Health, LLC, a proposed joint venture of Erlanger Health System and Acadia Healthcare, is applying for a Certificate of Need to establish a new psychiatric and substance abuse hospital Hamilton County.

This letter is to confirm that Acadia Healthcare will provide the approximately $25,112,600 in funding required to construct the hospital and implement that project. Acadia intends to finance these costs with cash on hand and borrowings from its existing $300 million revolving credit facility.

Acadia's most recent audited financial statements are provided in the application. Please let me know if you have any questions.

Sincerely,

David Duckworth
CFO

Supplemental #3
-COPY-

Erlanger Behavioral Health, LLC

CN1603-012

SUPPLEMENTAL #3
April 6, 2016
11:16 am

SUPPLEMENTAL INFORMATION (No. 3)

Erlanger Behavioral Health, LLC

Application To Initiate Psychiatric Services At The Intersection Of North Holtzclaw Avenue And Citico Avenue, In Chattanooga, Tennessee, With Establishment Of An Eighty-Eight (88) Bed Inpatient Hospital By The Addition Of Seventy-Six (76) Psychiatric Beds And The Transfer Of Twelve (12) Geriatric-Psychiatric Beds From *Erlanger North Hospital*

Application Number CN1603-012

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

SUPPLEMENTAL #3
April 6, 2016
11:16 am

Supplemental Responses To Questions Of The Tennessee Health Services & Development Agency

1.) Section C, Need, Item 1a (Project Specific Criteria-Psychiatric Inpatient Services), B.2 - Service Area Demographics and Section C, Need, Item 4.A, Service Area Demographics.

It is noted in the table on page 47 of the original application the Tennessee Department of Health's 2016 service area population of 930,858. However, the applicant provided a revised Tennessee service area population in Supplemental #2 of 1,015,247 to determine need. Please complete the following table and include data for each county in your proposed service area using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau.

Variable	*County 1*	*County 2*	*County 3*	*Etc.*	*Service Area*	*Tennessee*
0-17 Population-CY (2016)						
0-17 Population-PY (2020)						
0-17 Population % Change						
0-17 Population % of Total Population						
Current Year (CY), Age 65+						
Projected Year (PY), Age 65+						
Age 65+, % Change						
Age 65+, % Total (PY)						
CY, Total Population						
PY, Total Population						
Total Pop. % Change						
TennCare Enrollees						
TennCare Enrollees as a % of Total Population						
Median Age						
Median Household Income						
Population % Below Poverty Level						

Response

As requested, the demographic table has been updated and a replacement for page no. 47 has been attached to thi supplemental information.

2.) Section C., Economic Feasibility, Item 2 (Funding) & Item 10.

Acadia Funding Scenario

A. It is noted Acadia will finance a portion of the proposed project with a $300 million available revolving line of credit and cash reserves. However, the letter from Acadia Healthcare's CFO dated March 30, 2016 does not provide the percentage of the proposed project that will be funded by cash on hand and/or from a $300 million revolving line of credit. Please provide a revised letter from Acadia Healthcare's CFO that documents the percentage from each funding source and documents the availability of cash reserves. In addition, in the letter please clarify where the cash reserves will originate since Acadia's current ratio was 1:01:1 in the Consolidated Balance Sheet for the period ending December 31, 2015.

If Acadia plans to fund the project from a $300 million revolving line of credit, please provide a letter from a financial institution that identifies the expected interest rate, term of the loan, and any anticipated restrictions or conditions.

Please complete the following table:

Acadia Funding Scenario

Funding Source	Amount	As a % of Total
Cash		
Revolving Line of Credit		
Other (please specify)		
Total Loan Amount	$25,112,600	100%

Erlanger Health System Funding Scenario

B. It is noted the applicant has a non-binding agreement with Acadia to fund the proposed $25,112,600 project. In Supplemental #2, it is noted the applicant states Erlanger Health System has the funds to develop and implement the proposed project in the event Acadia is unable to execute as contemplated. It is understood that if the agreement with Acadia cannot be executed, the applicant will seek another partner. Since the applicant only has a non-binding agreement with another entity at this time, Erlanger must document the ability to solely fund the project, if necessary. Please provide appropriate documentation (letter) of funding for the proposed project from Erlanger Health System's Chief Financial Officer. If the funds will come from a bank loan, please provide a funding letter from a financial institution that identifies the expected interest rate, term of the loan, and any anticipated restrictions or conditions. If the funds will come from existing financial resources of Erlanger Health System, please identify which account in the financial balance sheet will fund the proposed project.

Please complete the following table:

Erlanger Health System Funding Scenario

Funding Source	Amount	As a % of Total
Cash		
Borrowed Funds		
Other (please specify)		
Total Loan Amount	$25,112,600	100%

Response

As to *Acadia Healthcare* and it's ability to fully fund this project, we have attached a letter from *Acadia's* CFO dated April 4, 2016, indicating that the project will be funded through the $ 300 M revolving credit facility. The chart for *Acadia* is below.

Acadia Funding Scenario

Funding Source	Amount	As a % of Total
Cash		
Revolving Line of Credit	$ 25,112,600	100 %
Other (please specify)		
Total Loan Amount	$ 25,112,600	100 %

Additionally, we will offer the following information pertaining to *Acadia*. The current ratio referenced is as of December 31, 2015, a discrete point in time. It should be noted that "the Company had $ 135.7 million of availability under the revolving credit facility as of December 31, 2015." Please see page F-22, paragraph 5, of the audited financial statements submitted with the SEC Form 10-K. Further, on page F-22 in paragraph 4, it states that "on February 16, 2016, the Company entered into a '*Second Incremental Facility Amendment*' … borrowings under the TLA Facility were used to pay down the majority of our $ 300 million revolving credit facility."

Therefore, as of February 16, 2016, most of *Acadia's* revolving credit facility is available to fully fund the project for *Erlanger Behavioral Health*.

As to *Erlanger Health Systems'* ability to fund the project should *Acadia* not be able to, please note on the audited financial statements for *Erlanger* which were submitted with this CON application, the current ratio for *Erlanger* is 2.63 to 1, as of June 30, 2015. Therefore, *Erlanger* has the ability to fully fund this project should the need arise. A letter from *Erlanger's* CFO is attached to this supplemental information.

As requested, the chart for *Erlanger* is below.

Erlanger Health System Funding Scenario

Funding Source	Amount	As a % of Total
Cash	$ 25,112,600	100 %
Borrowed Funds		
Other (please specify)		
Total Loan Amount	$ 25,112,600	100 %

SUPPLEMENTAL #3
April 6, 2016
11:16 am

A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger Behavioral Health, LLC

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 5 of April (Month), 2016 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

Shelia Hall
NOTARY PUBLIC

My commission expires June 9 (Month / Day), 2018.

SHELIA HALL
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

SUPPLEMENTAL #3
April 6, 2016
11:16 am

TABLE OF ATTACHMENTS

SUPPLEMENTAL #3
April 6, 2016
11:16 am

Description	Section / Item
Replacement Page 47	
CFO Letter - *Acadia Healthcare*	
CFO Letter - *Erlanger Health System*	

ATTACHMENTS

SUPPLEMENTAL #3
April 6, 2016
11:16 am

erlanger

April 4, 2016

Melanie M. Hill
Executive Director
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard,
Nashville, TN 37243

RE: Certificate or Need Application –CN 1603-012
Erlanger Behavioral Health, LLC

Dear Ms. Hill:

Erlanger Health System intends to enter into a joint venture with Acadia Healthcare wherein Acadia will fund development of the above referenced project. Should Acadia not follow thru to fund the project as anticipated, Erlanger would seek another partner to implement the proposed project.

Please let me know if further information is needed.

Sincerely,

J. Britton Tabor, CPA, FACHE
Executive V.P., CFO & Treasurer

Supplemental #4
-COPY-

Erlanger Behavioral Health, LLC

CN1603-012

SUPPLEMENTAL #4
April 12, 2016
9:42 am

SUPPLEMENTAL INFORMATION (No. 4)

Erlanger Behavioral Health, LLC

Application To Initiate Psychiatric Services At The Intersection Of North Holtzclaw Avenue And Citico Avenue, In Chattanooga, Tennessee, With Establishment Of An Eighty-Eight (88) Bed Inpatient Hospital By The Addition Of Seventy-Six (76) Psychiatric Beds And The Transfer Of Twelve (12) Geriatric-Psychiatric Beds From *Erlanger North Hospital*

Application Number CN1603-012

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

Supplemental Responses To Questions Of The Tennessee Health Services & Development Agency

1.) Section C, Economic Feasiility, Item 2 (Funding) & Item 10.

Acadia Funding Scenario

It is noted in Supplemental # 3 Acadia plans to fund the project from a $ 300 million revolving line of credit. As previously requested in Supplemental # 3, please provide a letter from a financial institution that identifies the amount of revolving credit available, the expected interest rate, term of the revolving line of credit, and any anticipated restrictions or conditions.

Erlanger Health System Funding Scenario

In Supplemental # 2, it is noted the applicant states Erlanger Healthsystem has the funds to develop and implement the proposed project in the event Acadia is unable to execute as contemplated. As requested by the Agency in Supplemental # 3, the applicant did not provide a funding letter from Erlanger, but instead provided a letter from Erlanger's Executive V.P, CFO and Treasurer that states Erlanger would seek another partner to implement the proposed project should Acadia not follow through to fund the project. Furthermore, the narrative response on page 5 of Supplemental # 3 reflected Erlanger would fund the $ 25,112,600 project with cash should Acadia not be able to. As previously requested in Supplemental # 3, please provide appropriate documentation (letter) of funding (cash) for the proposed project from Erlanger Health System's Chief Financial Officer in the event Acadia is unable to fund the proposed project and Erlanger is unable to find another partner. Since the funds will come from existing financial resources of Erlanger Health System, please identify which account in the financial balance sheet that will fund the proposed project.

Response

As to *Acadia Healthcare*, attached to this supplemental information is the requested letter from *Bank of America* outlining the revolving credit line which *Acadia* has previously referenced. Also, attached to this supplemental information is an updated *Agreement* between *Erlanger Health System* and *Acadia*. The new *Agreement* makes a binding commitment on the part of *Acadia* to *Erlanger* and the project.

As to *Erlanger's* portion of the response to this question, we believe that the new *Agreement* between *Erlanger* and *Acadia*, as well as the funding letter from *Bank of America* on *Acadia's* behalf addresses outstanding questions.

Additionally, we are also attaching to this supplemental information, a copy of correspondence from *Acadia* which outlines their commitment to this project and the local community, in terms of the human component as represented by current employees of *Erlanger's* Geriatric Psychiatric unit at *Erlanger North Hospital*. The correspondence demonstrates *Acadia's* commitment to all of these employees, by transferring current pay rates and length of service as well as making economic adjustments for any differences between benefit packages.

SUPPLEMENTAL #4
April 12, 2016
9:42 am

A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger Behavioral Health, LLC

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 11 of April (Month), 2016 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

Shelia Hall
NOTARY PUBLIC

My commission expires June 9 (Month / Day), 2018.

SHELIA HALL
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

TABLE OF ATTACHMENTS

SUPPLEMENTAL #4
April 12, 2016
9:42 am

Description	Section / Item
Correspondence - *Erlanger & Acadia*	
Funding Letter - *Acadia Healthcare*	
Letter Of Intent - Revised	

SUPPLEMENTAL #4
April 12, 2016
9:42 am

ATTACHMENTS

SUPPLEMENTAL #4
April 12, 2016
9:42 am

Winick, Joe

From: Steve Davidson <Steve.Davidson@acadiahealthcare.com>
Sent: Thursday, April 07, 2016 4:20 PM
To: Winick, Joe; Andy Hanner
Subject: RE: Erlanger

We would hire everybody that wants to transfer. They would need to be in good standing. (licenses current, etc.) and pass a criminal background check. At Southcoast, I believe all but two came over, one nurse transferred to a medical floor, and the program director took a nursing admin job.

We did a special recognition by having the transferred employees called "founders", with a plaque in the lobby of new hospital with their names, and a thank you gift ($50 gift card). They also preferred scrubs over other employee uniforms, so that stayed consistent

Titles may change, but pay rate and length of service is transferred. Benefit package may be a little different, but we mitigate that so economics are neutral on employees.

From: Winick, Joe [mailto:Joe.Winick@erlanger.org]
Sent: Thursday, April 07, 2016 3:12 PM
To: Andy Hanner
Cc: Steve Davidson
Subject: Erlanger

Andy – I am meeting tonight with the mental health staff at Erlanger North ...where we have the 12 bed geriatric program that we plan to integrate into new facility. I'm sure the key question from staff will revolve around employment prospects, opportunities, etc. in the new hospital. I would expect that Acadia would give current employees priority consideration relative to employment with the JV, but I wanted to get your thoughts on subject. I'd like to ease any discomfort to the extent possible. Your thoughts/guidance on this matter? Thanks much.

Joe

Joseph M. Winick, FACHE
Senior Vice President
Planning, Analytics & Business Development
Erlanger Health System
Office: (423) 778-8088 | Mobile: (423) 883-1287

SUPPLEMENTAL #4

April 12, 2016

Bank of America
Merrill Lynch

Global Commercial Banking
Bank of America, N.A.

CONFIDENTIAL

April 8, 2016

Melanie Hill
Executive Director
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard
Nashville, TN 37243

RE: CON Filing

Dear Melanie:

Please accept this letter as confirmation that Acadia Healthcare Company, Inc. (the "Customer") has been a client of Bank of America, N.A. (the "Bank") for a period of over 5 years. During this period, the Customer has satisfactorily fulfilled its obligations to the Bank.

The Bank is the administrative agent with respect to the Customer's $300 million secured revolving credit facility for the Customer (the "Credit Facility"). As of this date, the amount outstanding under the Credit Facility is currently in the $74 million figure range leaving approximately $206 million available. The Credit Facility has an interest rate of LIBOR plus 3.25%, which results in a current interest rate of approximately 3.69%. The revolving line of credit matures in February 2019. The availability of funds under the Credit Facility is subject to certain terms, conditions and covenants set forth in the Credit Facility.

This letter is being provided as a matter of courtesy at the request of the Customer. Please note that the information provided by the Bank in this letter is given as of the date of this letter and is subject to change without notice, and is provided in strict confidence to you for your own use only, without any responsibility, guarantee, representation, warranty (expressed or implied), commitment or liability on the part of the Bank, its parents, subsidiaries or affiliates or any of its or their directors, officers or employees to you or any third party, and none of them assumes any duties or obligations to you in connection herewith or any transaction between you or your affiliates and the Customer. This letter is not to be quoted or referred to without the Bank's prior written consent. The Bank cannot provide any opinions of the creditworthiness of the Customer or any of its affiliates, and the above information does not constitute an opinion of the Bank of the ability of the Customer to successfully perform its obligations under any agreement it may enter into with you, the Bank or any other person or entity.

The Bank has no duty and undertakes no responsibility to update or supplement the information set forth in this letter.

Very truly yours,

By: E. Mark Hardison
Name: Mark Hardison
Title: Senior Vice President

SUPPLEMENTAL #4
April 12, 2016
9:42 am

ACADIA HEALTHCARE

Direct Phone: 615-861-7339
Email: steve.davidson@acadiahealthcare.com

April 11, 2016

By Email (Joe.Winick@Erlanger.org)
Joseph M. Winick, FACHE
Senior Vice President
Planning, Analytics & Business Development
Erlanger Health System
975 E 3rd Street
Chattanooga, TN 37403

Re: Joint Venture for 88 Bed Behavioral Hospital – Letter of Intent

Dear Joe:

This letter reflects the terms of Acadia Healthcare Company, Inc.'s ("Acadia's") agreement to enter into a joint venture arrangement (the "Transaction") with Erlanger Health System ("Erlanger") to develop, build and operate a new 88-bed inpatient psychiatric facility (the "Facility") that would provide a full range of inpatient and outpatient behavioral health services, on or near the Erlanger campus.

1. **Proposed Transaction Structure.** Based upon the information available to us to date, Acadia anticipates a two stage transaction structure. During the first stage, Erlanger would form a new entity (the "Venture") to own and operate the Facility which, initially, would be wholly-owned by Erlanger. The parties rights and obligations during the first stage would be governed by a Pre-Organizational Agreement. Upon obtaining a final, non-appealable Certificate of Need to develop and operate the Facility (the "CON"), the Transaction would enter the second stage during which Acadia would become an owner of the Venture and the Facility would be developed. The parties rights and obligations during the second stage will be governed by an Operating Agreement.

2. **First Stage Responsibilities.** During the first stage, Erlanger, at its expense, will organize the Venture and will apply for and pursue obtaining the CON. Erlanger will pursue the CON to a final, non-appealable result. The parties acknowledge that Acadia's intended relationship with the Venture will need to be disclosed during the CON process. Acadia will incur the costs of architecture, engineering and design necessary for the CON application for the Facility. Additionally, Acadia will deliver a letter to the Venture which will outline its commitment to fund the construction and development of the Facility which the Venture may use in connection with the CON application. The Venture shall obtain or shall obtain the right to acquire the real

estate for the Facility. Erlanger and Acadia would share equally, if necessary, the cost of an option on the real estate for the Facility.

3. **Second Stage Responsibilities.**

a. **Ownership of the Venture.** Upon the Venture obtaining a final and non-appealable CON, Acadia will become a member of the Venture. Erlanger and Acadia would own a percentage interest in the Venture in proportion to the value of their respective contributions. The value of the contributions, and the resulting relative percentage ownership of the Venture would be based upon an independent fair market valuation.

b. **Profit and Loss.** Each member's share of profits, losses and distributions in the Venture would be proportional to that member's percentage interest in the Venture.

c. **Contributions.** For its capital contribution to the Venture, Acadia would contribute cash in an amount to be determined, to be used for the design and construction of the Facility. For its capital contribution to the Venture, Erlanger would contribute its geriatric-psych business operated at Erlanger North Hospital and the Erlanger brand name for the Facility. Additionally, Erlanger will be credited with the value that the Venture has relating to the fair market, appraised value of the CON.

d. **Definitive Agreements.** The obligations of the parties to consummate the Transaction would be set forth in "Definitive Agreements" acceptable to each party in its sole discretion. The Definitive Agreements would detail the parties' rights and responsibilities concerning capital contributions, pro rata profit distributions, duties owed to the entity and the minority members, restrictions on transfers of interests, put and call rights, other restrictive covenants, triggers for the unwinding of the Venture, and other customary terms and conditions for a transaction of this type. The initial Definitive Agreement would be the Venture's Pre-Organizational Agreement which will have the form of the Operating Agreement for the Venture (the "Operating Agreement") and a license agreement for the Erlanger brand name attached. It is contemplated that the Operating Agreement would be fully negotiated at the outset of the Transaction but would be signed upon obtaining the CON.

e. **Working Capital Financing.** The Venture would not incur any debt other than a line of credit from Acadia, commencing upon obtaining the CON, of up to $5,000,000 for (i) working capital; (ii) general corporate purposes; and (iii) startup expenses. The parties contemplate that the Venture will purchase the real estate on which the Facility will be located using this capital, or, in the alternative, that Acadia will acquire such real estate and contribute it to the

Venture. The line of credit would bear interest at the prime rate plus 2%, would be due in full in 60 months, and would be repaid in full before distributions of profit by the Venture. The Venture would not guarantee debt of Acadia or Erlanger.

4. **Closing Conditions.**

a. The stage one closing would be conditioned on the following:

1. execution and delivery of Definitive Agreements;
2. approval of the Transaction by Acadia's Board of Directors;
3. approval of the Transaction by Erlanger's Board of Directors;
4. regulatory, legal, and operational diligence approval by Erlanger; and
5. regulatory, legal, and operational diligence approval by Acadia.

b. The stage two obligations of the parties including the requirement for Acadia to fund construction and the requirement for Erlanger to contribute its geriatric-psych unit to the Venture shall be conditioned on the following:

1. no material adverse change in the CON, licensure category, or the prospects of the Facility;
2. approval of a CON for the Facility for at least 88 psychiatric beds;
3. zoning and similar land use approvals for the Facility's construction issuing from the appropriate governmental authorities;
4. receipt of a written opinion or opinions from independent third party appraiser(s) with expertise in healthcare transactions, that the consideration paid or contributed in exchange for member interests in the Venture is consistent with fair market value.

5. **Governance.** Beginning with stage two, the Venture would be subject to oversight by a "Board of Directors" appointed by the parties and voting based on the respective ownership interests represented, provided that in no event shall any party have less than two Board members. It is anticipated Acadia would have a controlling interest in the Venture and appointment rights over a majority of the Board of Directors. The following Board of Directors decisions would require approval of (a) a majority of the appointed individuals sitting on the Board of Directors and (b) at least one Board representative of each of the parties:

a. approving the Venture's strategic business plan;
b. determining the need for additional capital contributions;
c. approving the location and design of the Facility and construction budgets;
d. extraordinary capital expenditures including long term leases;
e. approving incurrence of extraordinary debt;
f. expanding or reducing the number of beds at the Facility;
g. admitting any new member;

h. creating or issuing additional membership interests and/or new classes of membership interests;
i. granting any lien or security interest (except for those in the ordinary course of business not in excess of $1,000,000) on or in any of the Venture's assets or property;
j. making loans to, or acquiring equity interests in, any other person or entity;
k. selling or otherwise disposing of assets of the Venture, other than in the ordinary course of business;
l. agreeing to any contract restricting the Venture's right to make distributions to its members, or agreeing to pay any distributions in respect of member units in any form other than cash or in any manner other than to the members in accordance with their membership percentage interests;
m. amending the Venture's articles or organization, operating agreement, or name;
n. entering into, renewing or terminating any lease, contract or agreement or any other transaction or arrangement (whether or not involving payments or remuneration) between the Venture and any member or affiliate of a member;
o. approving any transfer of the equity interests held by a member, whether by direct sale, merger, or exchange;
p. approving any merger, sale, restructuring, or recapitalization of the Venture or causing the Venture to convert to a different form of entity;
q. filing a petition requesting or consenting to an order for relief under the federal bankruptcy laws or to dissolve the Venture;
r. leasing any portion of the real property owned by the Venture other than in the ordinary course of business;
s. redeeming or repurchasing by the Venture of any member units, other than on a pro rata basis to all members;
t. hiring and retention of the CEO, CFO and CNO of the Facility;
u. entering into any corporate integrity agreement or settlement agreement in connection with any government investigation or whistleblower suit; and
v. making other extraordinary material decisions as set forth in the Definitive Agreements.

The Definitive Agreements would include a mechanism for resolving certain deadlocks that may arise in connection with a governance decision.

6. Financial Statements. The Definitive Agreements will provide for the delivery of annual Acadia-level consolidated and Venture-level audited, and monthly Venture-level unaudited financial statements of the Facility.

7. Charity Care Policy. The Operating Agreement will contain covenants ensuring that the Venture (i) is operated and managed in a manner that does not jeopardize Erlanger's tax-exempt status, and (ii) recognizes and promotes Erlanger's objective of providing charity care. Specifically, the Operating Agreement will provide that the Venture will provide healthcare services for a broad cross-section of the community, adopt high standards for the quality of

patient care, provide a reasonable level of charity care to the community served by the Venture and collaborate with Erlanger on the provision of uncompensated care.

8. **Corporate Office Services; Management.** Pursuant to a services agreement to be entered into between the Venture and Acadia, Acadia's corporate office would provide corporate office management services to the Venture, to include support in the following areas: operations management, finance and accounting, legal advice and counsel, internal audit, clinical quality and compliance, risk management, insurance, human resources, recruiting, payroll, information technology, tax, billing and collecting, marketing, managed care contracting, and business office support. Acadia would charge the Venture a management fee equal to 2% of the Venture's revenue for these corporate office services, and would pass through to the Venture without markup the following expenses: (a) the actual reasonable costs of outside consultants, legal counsel, tax counsel and outside auditors; (b) a proportional amount of Acadia's facilities' costs for software licenses, insurance and employee benefits; and (c) the direct costs of Adadia's call center, web design and marketing staff to the extent dedicated to marketing the Facility, not to exceed .05% of annual Venture revenue, the actual reimbursable third party expenses of Acadia's corporate office staff, incurred in providing services to the Venture, in accordance with Acadia's Expense Reimbursement Policy. As the anticipated majority member, Acadia would be responsible for the day-to-day operations, management and control of the Facility. Acadia would consolidate the results of the operations of the Facility with its company financial statements.

9. **Noncompetition.** The Definitive Agreements would provide that Acadia and Erlanger would covenant and agree with one another and each other's affiliates that, during the Non-Compete Period (defined below) and within the Non-Compete Area (defined below), they would not directly or indirectly, with the exception of the Facility and specified other exceptions, own, acquire, lease, manage, consult for, serve as agent or subcontractor for, finance, invest in, own any part of or exercise management control over any facility or business that primarily provides services that are the same or similar to the services provided by the Facility, provided that the non-compete will exclude care provided by Erlanger in any emergency department or any service provided in an acute care setting which is accompanied by or incidental to a general medical condition which requires the patient's presence at an Erlanger facility. The "Non-Compete Period" would, for each member respectively, commence on the date of such member's acquiring any membership interest in the Venture (each a "Membership Date") and terminate on the second anniversary of such member's liquidation or termination of all such membership interests. The "Non-Compete Area" would mean the area within a twenty-five (25) mile radius of the Facility, including any satellite locations thereof. In addition, during the Noncompete Period, the members shall not solicit for employment or employ any person (at or above a certain level) who is then employed by the Venture or a party, subject to exceptions for general solicitation activity not targeted as such persons.

10. **Access and Information.** The parties will furnish to one another and their respective representatives such CON, licensure, regulatory and such other information relating to the Transaction as another party or its representatives may from time to time reasonably request.

All such access, investigations, contacts and inspections to be conducted by the requesting party and its representatives shall be conducted in consultation with the other parties and in such a manner as not to interfere unduly with the normal conduct of the other parties' business.

11. **Confidentiality; Public Announcement.** The terms of this Letter of Intent are subject, in all respects, to section 3 of the parties' Memorandum of Understanding dated July ___, 2015 ("MOU"). In all other respects the MOU is hereby terminated. The timing and content of any announcements, press releases or any public statements concerning the Transaction (including the CON process) shall be determined by mutual agreement of the parties, unless, with respect to Acadia, in the judgment of Acadia upon advice of counsel, disclosure is otherwise required by Acadia by applicable law or by the applicable rules of any stock market on which Acadia's securities are listed or quoted, provided that Acadia shall use commercially reasonable efforts consistent with such applicable law to consult with Erlanger with respect to the text thereof.

12. **Exclusivity.** The parties contemplate the expenditure of substantial sums of time and money in connection with legal, accounting, financial, and due diligence work to be performed in conjunction with the proposed transaction prior to execution of the Definitive Agreements. For purposes of inducing one another to execute this Letter of Intent, during the period from the date of acceptance of this Letter of Intent specified below to July 31, 2016, the parties and their directors, officers, affiliates, agents and employees shall not, without the prior written consent of the other parties hereto, directly or indirectly, solicit or entertain offers from, negotiate with, or in any manner encourage, discuss, accept or consider any proposal of any other person relating to the acquisition, construction, joint venture, or management of a psychiatric or substance abuse facility similar in nature and location to the proposed Facility.

13. **Termination of Letter of Intent.** This Letter of Intent shall terminate upon the earliest to occur of (i) written notice of termination by Erlanger to Acadia; (ii) the execution of Definitive Agreements; or (iii) the failure of the parties to negotiate fully the Operating Agreement by December 31, 2016. Paragraphs 11 through 14 of this Letter of Intent shall survive the expiration or termination of this Letter of Intent.

14. **Governing Law.** This Letter of Intent shall be governed and construed in accordance with the laws of the State of Tennessee without regards to principles of conflicts of laws.

We are very pleased to submit this Letter of Intent. The Transaction is a priority for Acadia and we are prepared to commit the necessary resources to complete the Transaction expeditiously. Any questions regarding this Letter of Intent should be directed to Steve Davidson, Chief Development Officer, at 615-861-6000 or via email at steve.davidson@acadiahealthcare.com. We thank you for your consideration and look forward to working with you.

SUPPLEMENTAL #4
April 12, 2016
9:42 am

If you are in agreement with the terms of this Letter of Intent, please sign and return one copy to us and each party should retain one copy for its records.

Sincerely,

Steve Davidson
Chief Development Officer

Agreed and Accepted:

Erlanger Health System
By: Joseph M. Winick
Its: SVP

Supplemental #5
-COPY-

Erlanger Behavioral Health

CN1603-012

SUPPLEMENTAL #5
April 27, 2016
10:10 am

SUPPLEMENTAL INFORMATION (No. 5)

Erlanger Behavioral Health, LLC

Application To Initiate Psychiatric Services At The Intersection Of North Holtzclaw Avenue And Citico Avenue, In Chattanooga, Tennessee, With Establishment Of An Eighty-Eight (88) Bed Inpatient Hospital By The Addition Of Seventy-Six (76) Psychiatric Beds And The Transfer Of Twelve (12) Geriatric-Psychiatric Beds From *Erlanger North Hospital*

Application Number CN1603-012

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

Supplemental Responses To Questions Of The Tennessee Health Services & Development Agency

1.) Section B, Project Description, Item 1.

Please provide a replacement page 12 to reflect the revised ownership structure as reflected in the document *Unanimous Written Consent Action Of The Directors Of Erlanger Behavioral Health, LLC*.

Response

As requested, replacement pages 12 and 13 are attached to this supplemental information.

2.) Section C, Economic Feasibility, Item 2 (Funding).

Please provide a replacement page 53 to reflect the revised funding of the proposed project.

Response

As requested, replacement page 53 is attached to this supplemental information.

3.) Section C, Economic Feasibility, Item 4 (Projected Data Chart).

It is noted in the document *Unanimous Written Consent Action Of The Directors Of Erlanger Behavioral Health, LLC*, Acadia Healthcare Company, Inc, commits to provide a line of credit up to $ 5,000,000 to finance working capital, general corporate expenses, and start up expenses. Please submit a revised *Projected Data Chart* that reflects interest from the $ 5,000,000 Line of Credit as a Capital Expenditure.

Response

Acadia borrows and repays funds to its lender from its $300 million credit line for general corporate purposes, as needs dictate. Such borrowings are not project specific. As a result, no interest is charged to any one specific project.

4.) Section C, Economic Feasibility, Item 2 (Funding) & Item 10.

It is noted the funding for this proposed project has changed several times since the application was originally filed as evidenced by following original application and subsequent supplemental responses.

- March 15, 2016-Original application: Funded by Acadia, $25,112,600 with Cash on hand and revolving cash on hand.

- March 28, 2016-1st Supplemental Response: Acadia specifies its contribution will be cash. Acadia does not plan to utilize a credit facility to fund the proposed project.

- March 31, 2016-2nd Supplemental Response: Acadia Healthcare advises that they have a $300 million line of credit to fund the project. Interest on the credit line will be retained at the Acadia corporate level. Acadia will contribute cash to the Joint Venture to fund development costs so no interest expense is chargeable to the project.

- April 6, 2016-3rd Supplemental Response: A letter from Acadia's CFO indicates the project ($25,112,600) will be funded through a $300 million revolving credit facility.

- April 12, 2016-4th Supplemental Response: An April 8, 2016 letter from Bank of America states $206 million is available from Acadia $300 million secured revolving credit facility and matures in February 2019.

- April 19, 2016-Additional Information Submitted-In Unanimous Written Consent Action of the Directors of Erlanger Behavioral Health, LLC Exhibit-A Contribution Agreement (Contribution Agreement) Acadia commits to provide the cash necessary to fund the architecture, engineering, design, and construction of the new 88 bed inpatient psychiatric facility which is anticipated to be $25,000,000. The applicant

commits to provide a line of credit of up to $5,000,000 to finance working capital, general corporate expenses, and start-up expenses.

Furthermore, it is noted in the *Unanimous Written Consent Action of the Directors of Erlanger Behavioral Health, LLC Exhibit-A Contribution Agreement* that Acadia will finance $25,000,000 of the proposed project with cash reserves. However, it is noted the Acadia Healthcare Company, Inc. Consolidated Balance Sheet for the period ending December 31, 2015 reflected total current assets of $294,143,000 and current liabilities of $290,203,000 which calculates to a current ratio of 1.01 to 1. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities. According to this ratio formula, it appears Acadia does not have adequate current liquidity or reserves to appropriately fund the proposed project. Please identify which account in the Acadia financial balance sheet that will fund the proposed project.

In the latest supplemental response it is noted the applicant will provide a line of credit of up to $5,000,000 to finance working capital, general corporate expenses, and start-up expenses. Please explain why this line of credit is needed while Acadia will finance the $24,067,000 estimated project cost with cash.

Please clarify where the working capital, general corporate expenses, and start-up expenses previously mentioned are located in the Project Costs Chart.

In addition, please submit a revised funding letter from Acadia's CFO that reflects the language in the document titled Unanimous Written Consent Action of the Directors of Erlanger Behavioral Health, LLC Exhibit-A Contribution Agreement.

In Supplemental #2 the applicant states interest on the $300 million line of credit to fund the project will be retained at the Acadia corporate level. In addition, Acadia will contribute cash to the Joint Venture to fund development costs so no interest expense is chargeable to the project. Please explain how interest expense it not charged to the project

since it is a result of it. If needed, please revise the Projected Data Chart to reflect interest capital expenditures.

In summary, the applicant has changed the method of funding from the original application through the supplemental responses from Acadia funding the project through cash reserves, then line of credit, and then combination of cash reserves and line of credit. Please clarify how the proposed project will be funded and make any changes, if necessary, to include but not limited to the Project Costs Chart, Projected Data Chart, Funding Letter, Consent Action Agreement, and applicable replacement pages.

Response

As 49% owner of *Erlanger Behavioral Health, LLC*, the applicant, *Acadia* has committed to fund design and construction of the proposed 88 bed behavioral health facility using cash from its $300 million credit line with *Bank of America* and to provide a $5 million credit line. Documentation on the availability of funds from this credit line is attached.

The credit line is made available to fund any operating shortfalls that may arise during startup of the new hospital. However, such a credit line may not be required at all as projections for the first year of operation are very conservative. Based on the number of patients with co-existing medical and behavioral health conditions currently served by *Erlanger*, it is expected that utilization in the first year of operation will exceed projections, eliminating the need for the credit line altogether. In this regard, please see attached correspondence from Dr. Jennie Mahaffey, *Erlanger's* Chief Of Behavioral Health. This said, the credit line is available should unidentified needs arise that require supplemental funding.

Line 9 of the *Project Cost Chart* reflects the inclusion of start-up expenses.

Acadia borrows and repays funds to its lender from its $300 million credit line for general corporate purposes, as needs dictate. Such borrowings are not project specific.

As a result, no interest is charged to any one specific project.

We apologize if past communication has not been clear; however, we have attempted to respond to questions in an appropriate and factual manner. As 49% owner of *Erlanger Behavioral Health, LLC*, *Acadia Healthcare* is committed to provide $25,000,000, more or less, to fund design and construction of the new 88 bed hospital and to provide a credit line of up to $5,000,000 should same be required. We have updated the application to reflect these changes.

SUPPLEMENTAL #5
April 27, 2016
10:10 am

A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger Behavioral Health, LLC

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 25th of April (Month), 2016 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

JOY P. JACKSON
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

NOTARY PUBLIC

My commission expires October 9 (Month / Day), 2016.

TABLE OF ATTACHMENTS

SUPPLEMENTAL #5
April 27, 2016
10:10 am

Description	Section / Item
Replacement Page 12	
Replacement Page 13	
Replacement Page 53	
CFO Letter - *Acadia Healthcare*	
Bank Of America Letter	
Email Demonstrating Need For Inpatient Psychiatric Beds	

ATTACHMENTS

SUPPLEMENTAL #5
April 27, 2016
10:10 am

ACADIA
HEALTHCARE

April 26, 2016

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Frost Building, Third Floor
161 Rosa Parks Boulevard
Nashville, Tennessee 37203

RE: Financing Commitment
Erlanger Behavioral Health, LLC
Hamilton County

Dear Mrs. Hill:

As 49% owner of Erlanger Behavioral Health, LLC, the applicant, Acadia Healthcare commits to fund the architecture, engineering and design and construction of the new 88 bed hospital with a project cost of $25,000,000 more or less, and to provide a $5,000,000 credit line for working capital, general corporate purposes and startup expenses. The line of credit will bear interest at a rate of prime plus 2% due within 60 months and must be repaid prior to any distributions.

Acadia's most recent audited financial statements are provided in the application. Please let me know if you have any questions.

Sincerely,

David Duckworth
CFO

SUPPLEMENTAL #5

April 27, 2016
10:10 am

Bank of America
Merrill Lynch

Global Commercial Banking
Bank of America, N.A.

CONFIDENTIAL

April 8, 2016

Melanie Hill
Executive Director
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard
Nashville, TN 37243

RE: CON Filing

Dear Melanie:

Please accept this letter as confirmation that Acadia Healthcare Company, Inc. (the "Customer") has been a client of Bank of America, N.A. (the "Bank") for a period of over 5 years. During this period, the Customer has satisfactorily fulfilled its obligations to the Bank.

The Bank is the administrative agent with respect to the Customer's $300 million secured revolving credit facility for the Customer (the "Credit Facility"). As of this date, the amount outstanding under the Credit Facility is currently in the $74 million figure range leaving approximately $206 million available. The Credit Facility has an interest rate of LIBOR plus 3.25%, which results in a current interest rate of approximately 3.69%. The revolving line of credit matures in February 2019. The availability of funds under the Credit Facility is subject to certain terms, conditions and covenants set forth in the Credit Facility.

This letter is being provided as a matter of courtesy at the request of the Customer. Please note that the information provided by the Bank in this letter is given as of the date of this letter and is subject to change without notice, and is provided in strict confidence to you for your own use only, without any responsibility, guarantee, representation, warranty (expressed or implied), commitment or liability on the part of the Bank, its parents, subsidiaries or affiliates or any of its or their directors, officers or employees to you or any third party, and none of them assumes any duties or obligations to you in connection herewith or any transaction between you or your affiliates and the Customer. This letter is not to be quoted or referred to without the Bank's prior written consent. The Bank cannot provide any opinions of the creditworthiness of the Customer or any of its affiliates, and the above information does not constitute an opinion of the Bank of the ability of the Customer to successfully perform its obligations under any agreement it may enter into with you, the Bank or any other person or entity.

The Bank has no duty and undertakes no responsibility to update or supplement the information set forth in this letter.

Very truly yours,

By: E. Mark Hardison
Name: Mark Hardison
Title: Senior Vice President

414 Union Street, 4th Floor
TN1-100-04-17, Nashville, TN 37219-1697

SUPPLEMENTAL #5
April 27, 2016
10:10 am

Winick, Joe

From: Mahaffey, Dr. Jennie
Sent: Monday, April 25, 2016 10:25 AM
To: Winick, Joe
Subject: The need is great.

Good morning, Joe.

FYI, we have a VA patient who is day #5 in our ED currently waiting on a medical bed to open up at the VA because they also have no psych beds available. We also have 2 other patients in the ED waiting for Moc Bend currently. One is # 57 and the other is #45 on the wait list.

Jennie

Jennie Mahaffey, M.D.
Chief of Behavioral Health
UT Erlanger Behavioral Health
979 East 3rd Street, Ste A-443
Office:(423)778-2965
Fax: (423)778-2966

COPY

ADDITIONAL INFORMATION

Erlanger Behavioral Health, LLC

CN1603-012

UNANIMOUS WRITTEN CONSENT ACTION OF THE DIRECTORS OF ERLANGER BEHAVIORAL HEALTH, LLC

The following actions are taken and the following business is transacted by the unanimous written consent of the directors (the "**Directors**") of Erlanger Behavioral Health, LLC (the "**Company**"), as of April 18, 2016 pursuant to the Tennessee Limited Liability Company Act.

WHEREAS, the Directors are aware of that certain Contribution Agreement (the "**Contribution Agreement**") between Company and Acadia Healthcare Company, Inc., a Delaware corporation ("**Acadia**"), in substantially the form attached hereto as **Exhibit A**, which contemplates the Company's issuance of a forty-nine percent (49%) membership interest in the Company in return for a cash payment of One Dollar ($1) and the capital commitment to fund the design and construction of a new 88-bed inpatient psychiatric facility, as more particularly described in the Contribution Agreement (the "**Contribution**");

WHEREAS, the Directors have determined that the Contribution and related issuance of membership interest is in the best interest of the Company; and

WHEREAS, the Directors deem it advisable, desirable, and in the best interest of the Company to approve and authorize the Contribution Agreement and all other instruments and documents necessary or desirable in effecting the Contribution and the other transactions contemplated by the Contribution Agreement.

NOW THEREFORE, BE IT RESOLVED, that the Directors hereby approve and authorize the Contribution and in connection therewith, approve and authorize the execution of the Contribution Agreement on behalf of the Company, as well as any other instruments and documents necessary or desirable in effecting the Contribution;

FURTHER RESOLVED, that the Directors hereby approve and authorize the execution and delivery by any Authorized Officer (as hereinafter defined) of the Contribution Agreement with such additional changes as such Authorized Officer reasonably believes are in the best interest of the Company, and any other instruments and documents necessary or desirable in effecting the other transactions contemplated by the Contribution Agreement;

FURTHER RESOLVED, that Robert Brooks, FACHE, Jeff Woodard, Britt Tabor, FACHE, Gregg Gentry, and Joseph Winick (each an "Authorized Officer") be, and each of them hereby is, authorized and directed, from time to time and in the name and on behalf of the Company, to do and perform all acts, to make, execute, deliver, certify, or file all such agreements, certificates, instruments, deeds, leases, assignments, notices, and other documents as may be required by, or as such officer or officers deem necessary, proper, or desirable in connection with, the performance by the Company of the foregoing resolutions, to pay such fees required by or in furtherance of the foregoing resolutions, and to take all such other steps as they may deem necessary, advisable, or convenient and proper to carry out the intent of this and the foregoing resolutions, all such actions to be performed in such forms as such officer or officers shall approve and the performance or execution thereof by such officer or officers shall be conclusive evidence of the approval thereof by such officer or officers and by these Directors;

FURTHER RESOLVED, that any and all lawful actions previously taken by any Authorized Officer of the Company in connection with the transactions contemplated by the foregoing resolutions are hereby adopted, ratified, confirmed and approved in all respects as the acts and deeds of the Company.

IN WITNESS WHEREOF, the undersigned, being all of the Directors of the Company, have executed this written consent, which may be executed in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument, each of which counterpart originals may be executed by signatures transmitted by facsimile transfers, and such facsimile transfers will be considered to be original signatures, effective as of the date first above written.

DIRECTORS:

Gregg Gentry

Joseph Winick, FACHE

Robert Brooks, FACHE

Jeff Woodard

Britt Tabor, FACHE

Exhibit A

Conribution Agreement

(see attached)

CONTRIBUTION AGREEMENT

To Erlanger Behavioral Health, LLC:

1. General. This Contribution Agreement (the "**Agreement**") is presented to Erlanger Behavioral Health, LLC, a Tennessee limited liability company (the "**Company**"), by Acadia Healthcare Company, Inc., a Delaware corporation listed on the New York Stock Exchange (the "**Investor**"), for the purposes of subscribing for, and to induce the Company to issue to the Investor, a forty-nine percent (49%) membership interest in the Company (the "**Membership Interest**") in exchange for One Dollar ($1) and the Capital Commitment (as defined in Section 2).

2. Capital Commitment. Investor commits to provide cash necessary to fund the architecture, engineering, design and construction of a new 88-bed inpatient psychiatric facility (the "**Facility**") which amount is anticipated to be approximately $25,000,000, more or less. Upon the completion of the Facility, the membership interests in the Company held by Erlanger Health System and Investor shall be adjusted to reflect the relative fair market value of their capital contributions to the Company. The value of Erlanger Health System's capital contribution shall be determined by an independent fair market value appraisal.

3. Line of Credit. Investor commits to provide a line of credit of up to $5,000,000 to Company to finance: (i) working capital; (ii) general corporate purposes; and (iii) startup expenses. The line of credit will bear interest at a rate of prime plus 2%, due within 60 months and must be repaid prior to any distributions from the Company.

4. Transfer of Membership Interest. Investor agrees that it will not transfer, assign or encumber the Membership Interest without the prior written approval of the Company.

5. Investment Intent. The Membership Interest is being acquired for investment for the account of the Investor, with the intent that the Membership Interest shall be held for investment, without the present intent of participating directly or indirectly in a distribution of the Membership Interest, and without the participation of any other entity or person. The Investor understands that the representations and warranties contained herein are to be relied upon by the Company as a basis for the exemption of the issuance of the Membership Interest from the registration requirements of the Securities Act of 1933, as amended (the "**Act**"), and the exemptions from registration contained in applicable state securities laws. The issuance of the Membership Interest will not be registered under the Act or under any state securities laws, and the Membership Interest must be held by the Investor until (and the Company shall have no obligation to recognize any sale, assignment or other transfer thereof to any person unless) it is subsequently registered under the Act and under applicable state securities laws, or unless exemptions from the registration requirements of the Act and such laws are available and approved by counsel satisfactory to the Company. The Company is not obligated to register the Membership Interest under the Act or under any state securities laws. The Company is not obligated to take any action, except as may be required by law, necessary to make Rule 144 under the Act or any other method available for resales of the Membership Interest by the Investor.

6. Information and Disclosure. The Investor acknowledges that the Company has not prepared, and that it has not been requested by the Investor to prepare, a comprehensive written prospectus or disclosure statement in connection with the issuance of the Membership Interest, covering the business, operations, management, financial condition or prospects of the Company of the nature that otherwise might be required if the sale of the Membership Interest were required to be registered under

the Act. The Investor further acknowledges that the Company, prior to the date hereof, has furnished the Investor the opportunity to ask questions of and receive answers from the Company concerning the financial and business affairs of the Company and has afforded the Investor the opportunity to verify the accuracy of all information provided or made available to the Investor by the Company.

7. Assignment. This Agreement shall be binding upon and shall inure to the benefit of the parties hereto, and their respective successors and assigns.

8. Controlling Law; Amendment; Waiver; Remedies Cumulative. This Agreement shall be construed and enforced in accordance with the laws of the State of Tennessee. This Agreement may not be altered or amended except in writing signed by the Company and the Investor. The failure of any party hereto at any time to require performance of any provisions hereof shall in no manner affect the right to enforce the same. No waiver by any party hereto of any condition, or of the breach of any term, provision, warranty, representation, agreement or covenant contained in this Agreement, whether by conduct or otherwise, in any one or more instances shall be deemed or construed as a further or continuing waiver of any such condition or breach or a waiver of any other condition or of the breach of any other terms, provision, warranty, representation, agreement or covenant herein contained.

9. Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original. This Agreement shall become effective when one or more counterparts have been signed by each of the parties to this Agreement and delivered to each of the other parties to this Agreement.

[Signatures on following page]

This Contribution Agreement is effective as of April 18 2016.

Acadia Healthcare Company, Inc:

By: Steven T. Davidson
Its: Chief Development Officer

ACCEPTED:

Erlanger Behavioral Health, LLC:

By:
Its:

Dated: April 19, 2016

ADDITIONAL INFORMATION

(For Tennessee Department Of Mental Health & Substance Abuse)

Erlanger Behavioral Health, LLC

Application To Initiate Psychiatric Services At The
Intersection Of North Holtzclaw Avenue And Citico Avenue,
In Chattanooga, Tennessee, With Establishment
Of An Eighty-Eight (88) Bed Inpatient Hospital
By The Addition Of Seventy-Six (76) Psychiatric Beds
And The Transfer Of Twelve (12) Geriatric-Psychiatric Beds
From *Erlanger North Hospital*

Application Number CN1603-012

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

ADDITIONAL INFORMATION

1.) Please identify the target population to be served in the proposed chemical dependency program including age, types of diagnostic categories and projected lengths of stay. Will detoxification services be offered ? Identify any program models or program descriptions which will be used. Please provide data upon which you projected bed need for this program.

Response

Detoxification services will be offered by *Erlanger Behavioral Health* following the *12 Step Abstinence Model*. Length of stay for this unit is expected to be 12-15 days, and the target population is anyone needing assistance with substance abuse within the range of 18-64 years of age. Internal Medicine physicians will supervise medical treatment for patients in active withdrawal from any substance.

As to specific data upon which projected bed need was based, for the chemical dependency unit, the expertise of Acadia Healthcare in operating behavioral health hospitals was relied upon. Based on this experience, it is expected that the hospital should have a substance abuse component of approximately 20-25% of the total bed capacity … twenty-two (22) of the proposed eighty-eight bed facility.

Additionally, with the first supplemental information which was submitted, a total of 3,956 patients from MDC 20, the substance abuse medical diagnostic category, were identified as being discharged from Tennessee hospitals where the patient originated from the Tennessee counties in the defined service area. Therefore, with a 12-15 day ALOS for substance abuse, it is reasonable to conclude that the twenty-two (22) bed unit proposed in this project will be sustainable in the long term.

2.) Indicate the staffing pattern for each proposed program (including partial and outpatient) and identify where there is a shared staff across programs. Will any staff be shared with Erlanger Health system or Acadia ?

Response

The staff for *Erlanger Behavioral Health* will be dedicated to patient care and services for that facility. *Acadia* will provide support services as needed for operational oversight such as quality assurance, risk management, information systems and legal. There is a possibility that there could be some sharing of pharmacy services with *Erlanger Medical Center.* However, it is not anticipated that there would be any sharing of direct patient care staff, such as nursing.

As requested, the staffing for each unit at *Erlanger Behavioral Health* is below.

	No. Of Beds	== Avg. Daily Census ==== Year 1	Year 2	Year 3	Staffing For Year 2	Staffing For Year 3
Adult Psychiatric Unit	24.0	4.0	10.0	13.0	RN-5, MHT-3	RN-6, MHT-4
Gero Psychiatric Unit	24.0	12.0	18.0	20.0	RN-6, MHT-8	RN-6, MHT-10
Child & Adolescent Unit	18.0	4.0	10.0	11.0	RN-5, MHT-3	RN-5, MHT-3
Chemical Dependency Unit	22.0	4.1	9.9	12.8	RN-5, MHT-3	RN-6, MHT-4
Partial Hospitalization / Outpatient					RN-2, MHT-2	RN-2, MHT-2
Total	88.0	24.1	47.9	56.8	RN-23, MHT-19	RN-25, MHT-23

3.) If not explained in supplemental material, please complete the sentence on the top of page 35 (03/14/16 CON application) that begins "Because MBMHI treats those who are severely and persistently mentally ill, it is not expected that this project will impact it's services as that target patient population is ."

Response

The sentence on page 35 was originally intended to distinguish the type of patients which *Erlanger Behavioral Health* would see with those of *MBMHI*, the sentence would be completed as follows …

> "Because *MBMHI* treats those who are severely and persistently mentally ill, it is not expected that this project will impact it's services as that target patient population is not the same clientele that *Erlanger Behavioral Health* will treat."

4.) You have included projected utilization data for years 1 and 2. Please project by type of program and add a

year 3.

Response

As requested, the projected utilization table with occupancy by unit, has been revised to add data for year 3.

	No. Of Beds	==== Year 1 ==== ADC	Unit Occ.	==== Year 2 ==== ADC	Unit Occ.	==== Year 3 ==== ADC	Unit Occ.
Adult Psychiatric Unit	24.0	4.0	16.7%	10.0	41.7%	13.0	54.2%
Gero Psychiatric Unit	24.0	12.0	50.0%	18.0	75.0%	20.0	83.3%
Child & Adolescent Unit	18.0	4.0	22.2%	10.0	55.6%	11.0	61.1%
Chemical Dependency Unit	22.0	4.1	18.6%	9.9	45.0%	12.8	58.2%
Total	88.0	24.1		47.9		56.8	
Total Occupancy			27.4%		54.4%		64.5%

It should be noted that these utilization rates are generally conservative and actual utilization could be higher than projected.

5.) Please submit utilization and occupancy data for the gero-psychiatric program you currently operate.

Response

As requested, the utilization and occupancy information for the *Geriatric Psychiatric Unit* and *Erlanger North Hospital* is below.

	Erlanger North -- Geriatric Psychiatric Unit				
	No. Of Beds	Admits	Pt. Days	ALOS	Occ.
FY 2014-15	12.0	238	3,531	14.8	80.6%
FY 2013-14	12.0	262	3,628	13.8	82.8%
FY 2012-13	12.0	281	3,761	13.4	85.9%

6.) Please identify in your list of patient transfer agreements those that would be specific to this project. Other than a new agreement with MBMHI as specified in supplemental information, list other

agreements that will be solicited.

Response

As noted, we provided a list of patient transfer agreements currently in place for *Erlanger Medical Center* and it is expected that *Erlanger Behavioral Health* will have agreements with substantially all of these entities. In addition to the *MBMHI* agreement, it is anticipated that all potential referral sources within the defined service will have a transfer agreement (i.e.-hospitals, nursing homes, etc.). However, since it is in the early stage of development, it is difficult to say precisely what facilities will execute transfer agreements with *Erlanger Behavioral Health*.

7.) List your referral sources both for admission and discharge.

Response

As noted in question six (6), we have provided the list of patient transfer agreements which *Erlanger Medical Center* currently has and it is anticipated that there will be agreements with substantially all of these entities. However, since it is in the early stage of development, it is difficult to say precisely what facilities will execute transfer agreements with *Erlanger Behavioral Health*.

Pertaining to discharged patients which are transferred, discharge planning staff will work closely with the receiving facility to ensure patient stability and continuity of care. For patients which are discharged home and/or to the care of another behavioral health provider, outpatient follow-up services will be available to coordinate follow-up care.

8.) As part of your discussion of need, you emphasized disparities in behavioral healthcare for "Blacks, Latinos and Asian Americans." How will you address this ?

Response

It is anticipated that the regional development effort will include offering educational services and community outreach programs to the entities which have an affiliation with *Erlanger Behavioral Health*. The educational programming and community outreach to these underserved populations will focus on increasing awareness of signs and symptoms of behavioral health disorders. Further, information will be provided to make direct contact with *Erlanger Behavioral Health*.

Additionally, in the tradition of *Erlanger Health System*, members of these vulnerable and underserved populations will be treated without consideration of ability to pay for services which may be needed. Further, a culture of diversity will be promoted to ensure appropriate care for those in need.

9.) Other than Psychiatry, please list the other professional training affiliation planned.

Response

Other than Psychiatry, *Erlanger Behavioral Health* anticipates additional professional training affiliations. Consideration could be given to training programs for Advanced Practice Nurses in the Psychiatry/Mental Health specialty, as well as Licensed Clinical Social Work.

10.) You list public transportation as mode of access. How will patients from rural counties access your services ?

Response

While the proposed location for *Erlanger Behavioral Health* is accessible via public transportation in Chattanooga, patients from the rural counties will most likely be transported by a family member, legal guardian or other care giver. However, in emergency or crisis situations, the patient will most likely be transported by ambulance.

LETTER OF INTENT

LETTER OF INTENT
TENNESSEE HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Chattanooga Times Free Press, which is a newspaper of general circulation in Hamilton County, Tennessee, on or before March 10, 2016, for one day.

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et. seq.*, and the Rules of the Health Services & Development Agency, that Erlanger Behavioral Health, LLC, with an ownership type of for profit, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to construct a new psychiatric hospital with a total complement of eighty-eight (88) inpatient beds, to include services for inpatients, outpatients and substance abuse. Further, we are requesting approval to transfer twelve (12) licensed Geriatric – Psychiatric beds currently at Erlanger North Hospital to the new Erlanger Behavioral Health campus. This will create a net addition of seventy-six (76) new inpatient psychiatric beds. If approved, the number of hospital beds at Erlanger North Hospital will decrease from fifty seven (57) beds to forty-five (45) beds upon completion of the project. No other health care services will be initiated or discontinued.

The facility and equipment will be located at Erlanger Behavioral Health, at a site located at the intersection of North Holtzclaw Avenue & Citico Avenue, Chattanooga, Hamilton County, Tennessee, 37404. The total project cost is estimated to be $ 25,112,600.00.

The anticipated date of filing the application is March 15, 2016.

The contact person for this project is Joseph M. Winick, Sr. Vice President, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee, 37403, and by phone at (423) 778-7274.

Joseph M. Winick	March 8, 2016	Joseph.Winick@erlanger.org
	Date:	E-Mail:

The Letter Of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter Of Intent must contain the following statement pursuant to T.C.A. §68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

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STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
ANDREW JACKSON BUILDING, 6th FLOOR
500 DEADERICK STREET
NASHVILLE, TENNESSEE 37243

BILL HASLAM
GOVERNOR

E. DOUGLAS VARNEY
COMMISSIONER

April 18, 2016

Myranna Knight
6806 Lake Hollow Drive
Harrison, Tennessee 37341

Dear Ms. Knight:

Governor Haslam forwarded your correspondence to my office at the Tennessee Department of Mental Health and Substance Abuse Services for response. I appreciate your advocacy for the support of behavioral health facilities in Chattanooga, Tennessee as well as your sharing personal experiences.

Certificate of Need (CON) applications for new health facilities are reviewed by the Tennessee Health Services and Development Agency (THSDA). This is an independent agency consisting of several State officials, consumer representatives who voice the perspective of patients and families, members of the medical profession and caregivers. These applications are also analyzed by appropriate State departments regarding need for the facility, economic impact, sustainability and other factors. A public hearing is held to determine if a CON is to be issued for a new facility. More information about this procedure is available online at ***https://www.tn.gov/hsda***.

I am forwarding your letter to the THSDA Director, Melanie M. Hill at 502 Deaderick St., Andrew Jackson Building, 9th Floor, Nashville, TN 37243. In this way, the agency will hear your voice in support of a new behavioral health facility in Chattanooga.

Thank you for your advocacy and your work in promoting the health of Tennesseans.

Sincerely,

E. Douglas Varney
Commissioner

cc: Melanie M. Hill ✓

E-Mail Viewer

Message | Details | Attachments | Headers | Source

HTML

From: "Myranna Knight" <myranna.knight@gmail.com>
Date: 3/21/2016 5:03:51 PM
To: "Bill.Haslam@tn.gov" <Bill.Haslam@tn.gov>
Cc:
Subject: Advocacy for Mental Health Patients in Chattanooga

*** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. ***

Hello Governor Haslam,

I am a nursing student, and I have attached an advocacy letter below for the support of mental and behavioral health facilities in Chattanooga, TN. I hope to hear from you soon. Thank you.

Myranna Knight

Close

March 16, 2016

Myranna Knight

6806 Lake Hollow Drive

Harrison, TN 37341

(423) 413-0915

Governor Bill Haslam

1st Floor, State Capitol

Nashville, TN 37243

Dear Governor Bill Haslam:

I am writing to you as an advocator to encourage you to support the proposition from Erlanger Health System in Chattanooga for the permission to build a $25 million hospital for behavioral health for our city. There is a great need for a behavioral health hospital in our community, and this facility will create a positive affect for the people of Chattanooga.

I am currently a nursing student at the University of Tennessee at Chattanooga, and I have clinical experience within the mental and behavioral health population. I would like to share with you some information regarding behavioral health within our community as well as my personal observations regarding this health issue.

During my clinical time at an ICU one day, there was an individual who was under 24 hour monitoring. When I inquired about this, the health care professionals explained to me that this individual was waiting for a bed at Moccasin Bend, a local mental health institute in Chattanooga. The professionals then explained to me that many patients such as this one will often wait for a bed for days before they are able to be transferred to Moccasin Bend and to be evaluated and receive the appropriate treatment.

The Erlanger Senior Vice President for Analytics and Business Development quoted a statistic that stated approximately fifty percent of people within our community that suffer from a mental or behavioral health condition do not get care. I hope that this information proves the importance of this issue, and I hope that you understand that there is a greater need for facilities such as this than what is provided for our community.

This facility can aid our community and help provide available care for the people who you serve. I ask you to support this important issue, and I would appreciate if you would contact me on this matter in bettering the health of our people.

Sincerely,

Myranna Knight

Alecia L. Craighead

From: Melanie Hill
Sent: Tuesday, July 12, 2016 2:49 PM
To: Lowavia Eden; Mark Farber; Mark Ausbrooks; Phillip M. Earhart
Subject: FW: Letter of Support Erlanger Hospital Certificate of Need

Melanie

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

www.tn.gov/hsda
Phone: 615-741-2364
Fax: 615-741-9884

From: aprile@epbfi.com [mailto:aprile@epbfi.com]
Sent: Tuesday, July 12, 2016 12:07 PM
To: Melanie Hill
Subject: Letter of Support Erlanger Hospital Certificate of Need

July 12, 2016

Ms. Melanie Hill, Executive Director
502 Deaderick Street
Andrew Jackson Bldg., 9th Floor
Nashville, TN 37243

Re: Erlanger Hospital- Proposed Mental Health Facility
Letter of Support Certificate of Need

Dear Ms. Hill,

I wish to submit a letter of support for Erlanger Hospital's proposed development of a mental health facility in Hamilton County and the issuance of the Certificate of Need for consideration by the Health Services and Development Board.

I write to you as a person that has experienced what it is like to for family and advocates to access mental health inpatient treatment for loved ones, even with the best health insurance. There have been numerous times our insurance approved inpatient and there were no beds available at Parkridge Valley, or they stacked my family member in the hallway on a temporary bed.

I have no business interests in this matter at all.. My only concern is the obvious shortage that families like mine experience.

Secondly, our public hospital, Erlanger, should have inpatient facilities.

Even with the best insurance trying to gain access to inpatient treatment facilities is next to impossible due to lack of space in existing facilities. My family member has been through well over a decade of cycling inpatient. As a designated conservator, it is my responsibility to access care, and it is genuinely impossible with the current level of space.

As you know, there are only two private mental health facilities in Hamilton County; one serves youth and the other adults. These facilities are so overcrowded, at times; patients are placed on beds in the hallways. My family member spent days in the hallway of Parkridge Valley due to lack of space.

I find it mind boggling that Partridge Valley would object to an expansion of treatment options for the mentally ill that require inpatient.

Families and their loved ones do not need the problem of gaining access to treatment due to lack of space. Treatment should be readily available.

While I respect the idea that the existing mental health facilities should take the patient regardless of the availability of accommodations, I think this community should have a higher standard than beds in The lack of mental health inpatient facilities is simply unacceptable to any reasonable person.

Our community desperately needs our publically owned hospital to have mental health inpatient facilities.

Please Department of Health Services and Development Board approve Erlanger's Certificate of Need. I have experienced the shortage of space, first hand. No one wants their family member stacked in the hallways.
Finally, the people that answer your phones are so helpful to regular people like me.

May I be placed on a meeting notice list by email, if possible?

Sincerely,

April Eidson
11127 Worley Road
Soddy Daisy, TN 37379
aprile@epbfi.com
(423) 240-6704

April Eidson
11127 Worley Road
Soddy Daisy, TN 37379
(423) 240-6704

Alecia L. Craighead

From: Melanie Hill
Sent: Wednesday, July 13, 2016 1:45 PM
To: Lowavia Eden; Mark Ausbrooks
Subject: FW: Support for Erlanger's Proposed 88-Bed Mental Health Facility

Melanie

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

www.tn.gov/hsda
Phone: 615-741-2364
Fax: 615-741-9884

From: Halstead, Diane [mailto:Diane-Halstead@utc.edu]
Sent: Wednesday, July 13, 2016 10:54 AM
To: Melanie Hill
Subject: Support for Erlanger's Proposed 88-Bed Mental Health Facility

Dear Ms. Hill,

I hope you are the correct contact person for public input on Erlanger Hospital's proposed 88-bed mental health facility. If not, please forward this to the appropriate person(s).

I strongly urge the state to approve this project. There continues to be a huge excess in demand for beds in our current mental health facilities. There is substantial documentation on the extent of mental health problems in our society, and many mental health patients are remanded to correctional institutions rather than in mental health hospitals where they can receive the treatment they need.

As an educator in Tennessee for the past 20 years, I've dealt with many students suffering from mental health problems, and I've witnessed the devastation that can occur when their mental health problems are untreated. Student services on UTC's campus offer counseling and support, of course, but there is no substitute for in-patient treatment when it's needed in acute and serious situations.

There is simply no excuse for the state to allow its citizens to suffer when there is a simple solution: increase the number of available beds, facilities, and staff. Erlanger's proposed facility is greatly needed.

Please contact me at any time with questions or concerns.

Sincerely,

Diane Halstead, Ph.D.

Mary Harris Distinguished Professor of Entrepreneurship
The University of Tennessee at Chattanooga
College of Business
Department of Marketing and Entrepreneurship, #6156
615 McCallie Avenue
Chattanooga, TM 37403-2598
diane-halstead@utc.edu
PH: 423-425-4673
FAX: 423-425-4158

BURR FORMAN LLP

results matter

Jerry W. Taylor
jtaylor@burr.com
Direct Dial: (615) 724-3247

511 Union Street
Suite 2300
Nashville, Tennessee 37219

Office (615) 724-3200
Fax (615) 724-3290
Toll-free (866) 489-8542

BURR.COM

July 1, 2016

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street, 9th Floor
Andrew Jackson Building
Nashville, TN 37243-0200

Re: Erlanger Behavioral Health, LLC
CN1603-012

Dear Ms. Hill,

Parkridge Valley Child and Adolescent Services is a 108 bed hospital located in Hamilton County, dedicated to providing child and adolescent behavioral health services. Parkridge Valley Adult and Senior Services is a 64 bed hospital located in Hamilton County, dedicated to providing adult and senior behavioral health services. (Collectively, "Parkridge Valley" herein). Parkridge Valley hereby gives notice of its opposition to the Erlanger project referenced above.

The Erlanger project fails to meet the applicable criteria of need, economic feasibility and contribution to the orderly development of health care facilities and services, and the CON should be denied. Representatives of Parkridge Valley will attend the meeting on August 24, in order to explain its opposition in more detail. Thank you.

Sincerely yours,

Burr & Forman LLP

Jerry W. Taylor

Cc: Joseph M. Winick
Joseph.Winick@erlanger.org

CADAS
COUNCIL FOR ALCOHOL & DRUG ABUSE SERVICES
With CADAS You Can

8/8/2016

Melanie Hill
Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street
Andrew Jackson Building, 9th Floor
Nashville, TN 37243

Dear Melanie,
This letter is to serve as opposition to the proposed Certificate of Need (CON) for Erlanger Behavioral Health to build a mental health facility in Chattanooga Tennessee.

It is our understanding that portions of the CON can be opposed. To that end, CADAS opposes is the inclusion of 22 beds for substance abuse/chemical dependency treatment.

CADAS believes there are currently sufficient beds in the region for this population. The following organizations have residential and detoxification beds available for the population:

- Parkridge/Valley hospital – 16 detoxification beds
- Moccasin Bend Mental Health Institute - 150 beds (Mental health and Substance abuse combined)
- Volunteer Behavioral Health System – 17 detoxification beds
- Skyridge Hospital – 9 detoxification beds
- Focus Healthcare - 36 inpatient and detoxification beds
- CADAS - 96 inpatient and detoxification beds
- Highland Rivers Health (Dalton) - 29 detoxification beds.

All of these facilities provide substance abuse/chemical dependency medical detoxification services, many also offer residential rehabilitation services and outpatient services.

There are two additional organizations that offer lower levels of care (outpatient services) with higher levels of care (detoxification and residential rehabilitation) services available at other locations. These organizations are:

- Cumberland Heights

207 Spears Avenue • P.O. Box 4797 • Chattanooga, TN 37405
Phone: 423.756.7644 • Toll Free: 1.877.ATCADAS • Fax: 423.756.7646 • Web: www.CADAS.org

- Bradford Health Services

This makes a total of up to 139 detoxification beds and 203 residential rehabilitation beds without including Moccasin Bend Mental Health Institute's mixed use beds available in the region. CADAS believes these beds are sufficient for the substance abuse/chemical dependency needs of the community.

A second area of concern for CADAS is the economic feasibility of the project. The National Conference of State Legislatures opines that the intent of CON regulation is based on the basic assumption that an overbuilding of health care facilities results in health care price inflation, and/or a potential skewing of re-imbursement rates. A skewing of re-imbursement rates can occur when there are too many beds or services for the actual need or demand of said community and surrounding areas resulting in unfair leveraging of re-imbursement rates by insurance companies to achieve the lowest rates possible due to an overabundance of available beds or services. There is concern that the addition of 22 beds will create this scenario in the greater Chattanooga area.

A third issue is the potential for the addition of 22 substance abuse/chemical dependency beds to disturb the orderly development of effective health care in the greater Chattanooga community.

At present, there is a documented shortage of nurses, psychiatrists and other needed healthcare professionals in the greater Chattanooga market. The addition of this mental health facility will affect the region's ability to maintain adequate levels of service, particularly in nursing and psychiatry.

Further, detoxification services are currently offered by Skyridge Hospital, Valley Parkridge, CADAS, Focus Healthcare, Volunteer Behavioral Health Care System and Highland and Moccasin Bend Mental Health Institute. The addition of 22 beds could destabilize the ability of all providers to provide these services in an effective manner.

We look forward to an opportunity to elaborate on these issues at the hearing on the 24th of August.

Regards,

Paul Fuchcar
Executive Director

Erlanger Behavioral Health, LLC

Applicant Comments To HSDA Pertaining To CON Application
For A New Behavioral Health Hospital (No. CN1603-012)

The *Tennessee Department Of Mental Health and Substance Abuse* ("*TDMHSA*") submitted its findings to the Tennessee Health Services and Development Agency (HSDA) following a review of the CON application filed by Erlanger Behavioral Health, LLC for a new behavioral health hospital to be located in Hamilton County, Chattanooga, Tennessee, on June 28, 2016. Following are comments by the applicant, Erlanger Behavioral Health, LLC in response to the *TDMHSA* report.

Report of Tennessee Dept. Of Mental Health and Substance Abuse

TDMHSA has recommended approval of the CON application by the *Tennessee Health Services & Development Agency* ("*HSDA*"). *TDMHSA* states that the application addresses the priorities detailed in the Tennessee State Health Plan in that it "promotes these principles through addition of specialized healthcare" (p. 13, para. 3), that it " contributes to the orderly development of healthcare" and will "have a positive impact on the community and the mental health delivery system" (p. 15, para. 6).

The *TDMHSA* report includes an evaluation of need based on "staffed beds" as defined in the *Tennessee Joint Annual Report* ("*JAR*"), "the total number of adult and pediatric beds set up, staffed and in use" (p. 2, para. 4). "Staffed beds" is an appropriate measure of available bed supply as the full complement of "licensed beds" may not otherwise be available for use by patients for a number of reasons, including use of bed space for other services, use of semi-private rooms for private beds, etc. The *TDMHSA* analysis of bed need included in the current supply of staffed beds *River Park Hospital* (10 beds) and *Starr Regional Medical Center* (10 beds); Starr Regional reported 7 geriatric psychiatric beds in their 2014 JAR Report with these beds operating at 114% occupancy (attached). River Park Hospital reported zero (0) staffed beds for Psychiatric Services in their 2014 JAR's (attached). Also, the *TDMHSA* report only included forty eight (48) beds for *Parkridge Valley Adult Hospital*; however, this facility actually has sixty-four (64) licensed psychiatric hospital beds. The *TDMHSA* report stated that *Parkridge West Hospital* closed on April 4, 2016 … while the medical / surgical component has closed … the behavioral health unit with twenty (20) beds is reported to be open. Finally, the *TDMHSA* report also listed the total population for the Tennessee portion of the service area as 1,218,509; however, we believe the correct population for 2016 is 1,015,247 and 1,049,445 for 2020 (attached; Boyd Center for Business & Economic Research, Haslam College of Business,

University of Tennessee/Knoxville). With these items considered, an adjusted bed need calculation follows below.

	Total Psych / SA	== Total Psych / Chemical Beds Reported By Erlanger == Child & Youth	Adult Psych	Geriatric	Chemical Dependency	Total	Total Beds Reported By TDMH
Parkridge Valley Adult - Chattanooga, TN	108	108				108	108
Parkridge Valley Child / Adolescent - Chattanooga, TN	64		32	16	16	64	48
Parkridge West Hospital - Jasper, TN	20		20			20	0
Erlanger North Hospital - Chattanooga, TN	12			12		12	12
Moccasin Bend MHI - Chattanooga, TN	150		150			150	150
Skyridge Medical Center - Westside - Cleveland, TN	29		29			29	30
Southern Tenn Med Ctr - Winchester, TN	12		12			12	12
Starr Regional Med Ctr - Etowah, TN	10			10		10	10
River Park Hospital - McMinnville, TN	0					0	10
Hamilton Medical Center - Dalton, GA	7		7			7	7
DeKalb Regional Medical Center - Fort Payne, AL	18			18		18	18
Total	430	108	250	56	16	430	405

	==== Pop. Est. 2016 ==== Tenn.	Non-Tenn.	== Pop. Est. 2020 === Tenn.	Non-Tenn.
Child (Age 0-14)	172,951	111,190	171,916	105,829
Adolescent (Age 15-17)	42,402	24,437	45,217	27,099
Adult (Age 18-64)	595,632	344,981	598,660	343,305
Geriatric (Age 65+)	203,262	97,806	233,652	108,586
	1,015,247	578,414	1,049,445	584,819
Total Est. Psychiatric Bed Need - 2016	478			
Total Est. Psychiatric Bed Need - 2021	490			

	== Est. Beds Required == 2016	2020	Current Supply	==== Est. Need ==== 2016	2020	Proposed Bed Mix
Child / Adolescent Beds - Est. Need - 2016	105	105	108	-3	-3	18
Adult Beds - Est. Need - 2016	282	283	266	16	17	46
Geriatric Beds - Est. Need - 2016	90	102	56	34	46	24
Total	477	490	430	47	60	88

(**) Substance Abuse beds included in Adult Psychiatric beds.

The table above reflects a net need of forty-seven (47) beds for the service area in 2016, and sixty (60) beds in 2020, including the 12 psychiatric beds at Erlanger North to be transferred to the new hospital, net of occupancy or access considerations. While the proposed facility is eighty-eight (88) beds, a need remains for the additional beds … as stated by *TDMHSA*, "application of the formula sometimes results in an under estimation of the number of inpatient psychiatric beds needed" (p. 2, para. 3). Further, *TDMHSA* is correct in stating that "other factors are relevant for consideration" (p. 6, para.5). Specifically, the occupancy rate for *Moccasin Bend Mental Health Institute* ("*MBMHI*") is 91.1%, and for the other mental health hospitals in Hamilton County is 82.8%. In addition, "Parkridge Valley does not accept uncompensated care patients and some involuntary admissions, but only those with insurance" (p. 6, para. 5).

The *TDMHSA* report incorrectly stated that Erlanger's amount of cash on hand was $11.215 million; the correct amount from the FY 15 audited financial statement is $92.64 million.

In addition, the *TDMHSA* report identified three (3) sub-acute providers of chemical dependency detoxification services (p. 3, Chart – "Other Detox Beds"). While these beds were not included in the bed need calculation by *TDMHSA*, we think the comparison is not appropriate because these are essentially community based "step down" beds, which are not interchangeable with or licensed as acute psychiatric beds. They do not provide the same level of services. We have similar concerns about use of these beds by patients with co-morbid medical and behavioral health conditions, those who are suicidal as well as by women in the third trimester of pregnancy given the high risk to newborns and the alarming rate of neonatal abstinence syndrome.

One of the non-hospital providers which *TDMHSA* identified was the *Council for Alcohol & Drug Abuse Services* ("*CADAS*") with 12 detox beds. On the *CADAS* website, the level of care which they self- identify as providing is "medically monitored detoxification", which is Level III.7-D according to the website for the *American Society of Addiction Medicine* ("*ASAM*") . This level of care is significantly different from the level of care which will be provided by *Erlanger Behavioral Health*, which is Level IV-D and appropriately described as Medically Managed Intensive Inpatient Detoxification. As may be seen from this illustration, there is a significant difference between "*medically monitored*" and "*medically managed intensive*" levels of care. These levels of care are rightfully differentiated given the nature of the patients served and the resources utilized for these patients. The non-hospital providers also do not treat Medicare patients because the *Centers For Medicare & Medicaid Services* ("*CMS*") does not certify these beds and does not reimburse for the lower level of "step down" care; Medicare only reimburses for services rendered in certified acute facilities which *EBH* will provide. Accordingly, we do not think the comparison of the non-hospital providers by *TDMHSA* was appropriate.

4. A. Number of Beds Set Up and Staffed on a typical day

SERVICE	BEDS
Medical	0
Surgical	0
Medical/Surgical	0
Obstetrics	0
Gynecological	0
OB/GYN	0
Pediatric	0
Eye	0
Neonatal Care	0
Intensive Care (excluding Neonatal)	0
Orthopedic	0
Urology	0
Rehabilitation	0
Chronic/Extended Care	0
Pulmonary	0
Psychiatric	7
Psychiatric specifically for Children and Youth under age 18	0
Psychiatric specifically for Geriatric Patients	7
Chemical Dependency	0
Chemical Dependency specifically for Children and Youth under age 18	0
Chemical Dependency specifically for Geriatric Patients	0
Swing Beds (for long term skilled or intermediate care)	0
Other, specify	0
Unassigned	0
TOTAL	7

STAFF REGIONAL

B. Number of Patients in hospital on a typical day. Exclude normal newborns (See Instructions), long term skilled or intermediate patients. 8

5. OBSERVATION BEDS

A. Do you use inpatient staffed beds for 23-hour observation? ○ YES ◉ NO If yes, number of beds 0

B. Do you have beds assigned to dedicated 23-hour observation unit? ○ YES ◉ NO If yes, number of beds 0

C. Do you have beds in a "same-day-surgery" unit that are used for both same-day surgery and 23-hour observation? ○ YES ◉ NO
If yes, number of beds 0

SCHEDULE G - UTILIZATION* State ID 54233

1. INPATIENT UTILIZATION (include normal newborns)
   Patient Census Records:
   Please indicate whether you are reporting Admissions and Inpatient Days ◉
   or Discharges and Discharge Patient Days ○

2. UTILIZATION BY MAJOR DIAGNOSTIC CATEGORIES:

MAJOR DIAGNOSTIC CATEGORIES	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS
01 Nervous System	21	75
02 Eye	0	0
03 Ear, Nose, Mouth and Throat	5	13
04 Respiratory System	88	292
05 Circulatory System	47	131
06 Digestive System	22	72
07 Hepatobiliary System & Pancreas	5	17
08 Musculoskeletal Sys. & Connective Tissue	4	21
09 Skin, Subcutaneous Tissue & Breast	5	21
10 Endocrine, Nutritional & Metabolic	18	48
11 Kidney & Urinary Tract	24	70
12 Male Reproductive System	1	2
13 Female Reproductive System	0	0
14 Pregnancy, Childbirth & the Puerperium	0	0
15 Normal Newborns & Other Neonates with Conditions Originating in the Perinatal Period	0	0
16 Blood and Blood Forming Organs and Immunological Disorders	5	14
17 Myeloproliferative Disorders & Poorly Differentiated Neoplasms	0	0
18 Infectious & Parasitic Diseases	14	46
19 Mental Diseases & Disorders	257	2,925
20 Alchohol/Drug Use & Alcohol/Drug-Induced Organic Mental Disorders	1	3
21 Injuries, Poisoning, & Toxic Effects of Drugs	4	8
22 Burns	0	0
23 Factors Influencing Health Status and Other Contacts with Health Services	2	8
24 Multiple Significant Trauma	0	0
25 Human Immunodeficiency Virus Infections	0	0
26 Other DRGs Associated with All MDCs	0	0
TOTAL	523	3,766

SMAR Regional

REPORT 2A
REPORT FOR HOSPITALS 2014

HOSPITALS LICENSED IN TENNESSEE
SELECTED UTILIZATION BY TYPE OF HOSPITAL

SOUTHEAST REGION

County	Facility	Type of Service	Staffed Beds	Discharge/ Inpatient Days	Staffed Bed Days Open	Staffed Beds Percent Occupancy	Licensed Beds	Licensed Bed Days Open	Licensed Beds Percent Occupancy	Discharges or Admissions	Average Length of Stay	Average Daily Census
GENERAL HOSPITALS, SPECIALTY HOSPITALS, MEDICAL CENTERS												
REGION TOTAL			529	84,199	193,085	43.6	859	313,535	26.9	18,369	4.6	231
Bledsoe	Erlanger Bledsoe	Other	25	1,687	9,125	18.5	25	9,125	18.5	289	5.8	5
Bradley	Skyridge Medical Center	Med-Surg	156	31,708	56,940	55.7	251	91,615	34.6	7,117	4.5	87
	Skyridge Medical Center Westside	Med-Surg	30	4,107	10,950	37.5	100	36,500	11.3	841	4.9	11
Franklin	Southern Tennessee Regional Health System - Sewanee	Med-Surg	21	1,532	7,665	20.0	21	7,665	20.0	432	3.5	4
	Southern Tennessee Regional Health System - Winchester	Med-Surg	103	18,277	37,595	48.6	152	55,480	32.9	3,874	4.7	50
McMinn	Starr Regional Medical Center	Med-Surg	63	8,365	22,995	36.4	118	43,070	19.4	2,285	3.7	23
	Starr Regional Medical Center Etowah	Med-Surg	45	3,766	16,425	22.9	72	26,280	14.3	523	7.2	10
Marion	Grandview Medical Center Jasper	Med-Surg	36	7,587	13,140	57.7	70	25,550	29.7	1,200	6.3	21
Polk	Copper Basin Medical Center	Med-Surg	25	3,644	9,125	39.9	25	9,125	39.9	791	4.6	10
Rhea	Rhea Medical Center	Med-Surg	25	3,526	9,125	38.6	25	9,125	38.6	1,017	3.5	10

River Park Hospital
JAR - 2014

4. A. Number of Beds Set Up and Staffed on a typical day

SERVICE	BEDS
Medical	0
Surgical	0
Medical/Surgical	86
Obstetrics	6
Gynecological	0
OB/GYN	0
Pediatric	0
Eye	0
Neonatal Care	0
Intensive Care (excluding Neonatal)	8
Orthopedic	0
Urology	0
Rehabilitation	15
Chronic/Extended Care	0
Pulmonary	0
Psychiatric	0
Psychiatric specifically for Children and Youth under age 18	0
Psychiatric specifically for Geriatric Patients	0
Chemical Dependency	0
Chemical Dependency specifically for Children and Youth under age 18	0
Chemical Dependency specifically for Geriatric Patients	0
Swing Beds (for long term skilled or intermediate care)	10
Other, specify	0
Unassigned	0
TOTAL	125

B. Number of Patients in hospital on a typical day. Exclude normal newborns (See Instructions), long term skilled or intermediate patients. 31

5. OBSERVATION BEDS

A. Do you use inpatient staffed beds for 23-hour observation? (•) YES ( ) NO If yes, number of beds 4

B. Do you have beds assigned to dedicated 23-hour observation unit? ( ) YES (•) NO If yes, number of beds 0

C. Do you have beds in a "same-day-surgery" unit that are used for both same-day surgery and 23-hour observation? ( ) YES (•) NO
If yes, number of beds 0

REPORT 2A
REPORT FOR HOSPITALS 2014

HOSPITALS LICENSED IN TENNESSEE
SELECTED UTILIZATION BY TYPE OF HOSPITAL

UPPER CUMBERLAND REGION

County	Facility	Type of Service	Staffed Beds	Discharge/ Inpatient Days	Staffed Bed Days Open	Staffed Beds Percent Occupancy	Licensed Beds	Licensed Bed Days Open	Licensed Beds Percent Occupancy	Discharges or Admissions	Average Length of Stay	Average Daily Census
GENERAL HOSPITALS, SPECIALTY HOSPITALS, MEDICAL CENTERS												
REGION TOTAL			861	141,335	314,265	45.0	1,037	378,505	37.3	31,530	4.5	387
Cannon	Stones River Hospital	Med-Surg	50	4,816	18,250	26.4	60	21,900	22.0	794	6.1	13
Clay	Cumberland River Hospital	Med-Surg	34	4,072	12,410	32.8	36	13,140	31.0	609	6.7	11
Cumberland	Cumberland Medical Center	Med-Surg	122	24,244	44,530	54.4	189	68,985	35.1	5,489	4.4	66
DeKalb	DeKalb Community Hospital	Med-Surg	56	3,363	20,440	16.5	71	25,915	13.0	940	3.6	9
Fentress	Jamestown Regional Medical Center	Med-Surg	75	7,099	27,375	25.9	85	31,025	22.9	1,647	4.3	19
Macon	Macon County General Hospital	Med-Surg	25	3,121	9,125	34.2	25	9,125	34.2	817	3.8	9
Overton	Livingston Regional Hospital	Med-Surg	82	14,233	29,930	47.6	114	41,610	34.2	2,611	5.5	39
Putnam	Cookeville Regional Medical Center	Med-Surg	243	57,110	88,695	64.4	247	90,155	63.3	13,393	4.3	156
Smith	Riverview Regional Medical Center South	Other	25	6,294	9,125	69.0	25	9,125	69.0	1,183	5.3	17
Warren	River Park Hospital	Med-Surg	125	11,341	45,625	24.9	125	45,625	24.9	2,935	3.9	31
White	Highlands Medical Center	Med-Surg	24	5,642	8,760	64.4	60	21,900	25.8	1,112	5.1	15
MENTAL HEALTH INSTITUTES, MENTAL HEALTH CENTERS												
REGION TOTAL			38	5,060	13,870	36.5	38	13,870	36.5	879	5.8	14
Putnam	PremierCare Tennessee, Inc.	Psych	38	5,060	13,870	36.5	38	13,870	36.5	879	5.8	14

Population For Service Area

	Total Pop. CY 2016	Total Pop. CY 2020	0-17 Pop. CY 2016	0-17 Pop. CY 2020	18+ Pop. CY 2016	18+ Pop. CY 2020	65+ Pop. CY 2016	65+ Pop. CY 2020	18-64 Pop. CY 2016	18-64 Pop. CY 2020
Hamilton County, TN	356,156	368,666	77,582	80,402	278,574	288,264	61,073	69,752	217,501	218,512
Bradley County, TN	105,549	109,706	23,615	23,841	81,934	85,865	17,879	20,381	64,055	65,484
Marion County, TN	28,585	28,633	5,911	5,703	22,674	22,930	5,763	6,584	16,911	16,346
Grundy County, TN	13,470	13,263	2,882	2,695	10,588	10,568	3,021	3,339	7,567	7,229
Sequatchie County, TN	15,835	16,943	3,407	3,501	12,428	13,442	3,195	3,896	9,233	9,546
Bledsoe County, TN	13,273	13,481	2,601	2,546	10,672	10,935	2,628	2,955	8,044	7,980
Rhea County, TN	33,934	35,216	7,677	7,606	26,257	27,610	6,589	7,571	19,668	20,039
Meigs County, TN	12,221	12,462	2,352	2,220	9,869	10,242	2,677	3,151	7,192	7,091
McMinn County, TN	54,449	55,724	11,636	11,592	42,813	44,132	11,089	12,650	31,724	31,482
Polk County, TN	17,442	17,812	3,571	3,524	13,871	14,288	3,680	4,134	10,191	10,154
Coffee County, TN	55,932	57,865	13,140	13,331	42,792	44,534	10,225	11,573	32,567	32,961
Cumberland County, TN	61,910	65,575	10,702	10,767	51,208	54,808	19,871	23,106	31,337	31,702
Franklin County, TN	42,097	42,681	8,610	8,158	33,487	34,523	8,752	9,972	24,735	24,551
Loudon County, TN	54,261	57,923	10,069	10,311	44,192	47,612	15,089	17,908	29,103	29,704
Monroe County, TN	47,980	50,062	10,186	10,083	37,794	39,979	10,398	12,384	27,396	27,595
Roane County, TN	55,630	56,301	10,683	10,324	44,947	45,977	12,670	14,509	32,277	31,468
Van Buren County, TN	5,651	5,686	1,056	992	4,595	4,694	1,313	1,554	3,282	3,140
Warren County, TN	40,872	41,446	9,673	9,537	31,199	31,909	7,350	8,233	23,849	23,676
** → *Total - Tennessee*	1,015,247	1,049,445	215,353	217,133	799,894	832,312	203,262	233,652	596,632	598,660
Dade County, GA	16,480	16,571	3,262	3,118	13,218	13,453	2,889	3,221	10,329	10,232
Walker County, GA	68,154	68,576	15,052	14,548	53,102	54,028	11,988	13,424	41,114	40,604
Catoosa County, GA	66,244	68,063	15,258	14,909	50,986	53,154	10,789	12,212	40,197	40,942
DeKalb County, AL	70,940	71,111	17,601	17,268	53,339	53,843	11,494	12,596	41,845	41,247
Jackson County, AL	52,763	52,717	11,212	10,768	41,551	41,949	10,220	11,288	31,331	30,661
Chatooga County, GA	24,450	23,811	5,419	5,168	19,031	18,643	4,157	4,459	14,874	14,184
Fannin County, GA	24,131	24,727	4,311	4,263	19,820	20,464	6,155	6,823	13,665	13,641
Gilmer County, GA	29,086	29,911	6,041	6,048	23,045	23,863	6,372	7,148	16,673	16,715
Gordon County, GA	56,214	57,299	14,354	14,197	41,860	43,102	7,781	8,801	34,079	34,301
Murray County, GA	39,229	39,724	10,001	10,020	29,228	29,704	5,300	5,989	23,928	23,715
Whitfield County, GA	103,211	104,465	28,274	27,927	74,937	76,538	13,297	14,593	61,640	61,945
Cherokee County, NC	27,512	27,844	4,842	4,694	22,670	23,150	7,364	8,032	15,306	15,118
** → *Total - Out Of State*	578,414	584,819	135,627	132,928	442,787	451,891	97,806	108,586	344,981	343,305
Grand Total	1,593,661	1,634,264	350,980	350,061	1,242,681	1,284,203	301,068	342,238	941,613	941,965

RULES
OF
HEALTH SERVICES AND DEVELOPMENT AGENCY

CHAPTER 0720-11
CERTIFICATE OF NEED PROGRAM – GENERAL CRITERIA

TABLE OF CONTENTS

0720-11-.01 GENERAL CRITERIA FOR CERTIFICATE OF NEED. The Agency will consider the following general criteria in determining whether an application for a certificate of need should be granted:

(1) Need. The health care needed in the area to be served may be evaluated upon the following factors:

(a) The relationship of the proposal to any existing applicable plans;

(b) The population served by the proposal;

(c) The existing or certified services or institutions in the area;

(d) The reasonableness of the service area;

(e) The special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities, TennCare participants, and low-income groups;

(f) Comparison of utilization/occupancy trends and services offered by other area providers;

(g) The extent to which Medicare, Medicaid, TennCare, medically indigent, charity care patients and low income patients will be served by the project. In determining whether this criteria is met, the Agency shall consider how the applicant has assessed that providers of services which will operate in conjunction with the project will also meet these needs.

(2) Economic Factors. The probability that the proposal can be economically accomplished and maintained may be evaluated upon the following factors:

(a) Whether adequate funds are available to the applicant to complete the project;

(b) The reasonableness of the proposed project costs;

(c) Anticipated revenue from the proposed project and the impact on existing patient charges;

(d) Participation in state/federal revenue programs;

(e) Alternatives considered; and

(f) The availability of less costly or more effective alternative methods of providing the benefits intended by the proposal.

(3) Contribution to the Orderly Development of Adequate and Effective Healthcare Facilities and/or Services. The contribution which the proposed project will make to the orderly development of an adequate and effective health care system may be evaluated upon the following factors:

(Rule 0720-11-.01, continued)

(a) The relationship of the proposal to the existing health care system (for example: transfer agreements, contractual agreements for health services, the applicant's proposed TennCare participation, affiliation of the project with health professional schools);

(b) The positive or negative effects attributed to duplication or competition;

(c) The availability and accessibility of human resources required by the proposal, including consumers and related providers;

(d) The quality of the proposed project in relation to applicable governmental or professional standards.

(4) Applications for Change of Site. When considering a certificate of need application which is limited to a request for a change of site for a proposed new health care institution, The Agency may consider, in addition to the foregoing factors, the following factors:

(a) Need. The applicant should show the proposed new site will serve the health care needs in the area to be served at least as well as the original site. The applicant should show that there is some significant legal, financial, or practical need to change to the proposed new site.

(b) Economic factors. The applicant should show that the proposed new site would be at least as economically beneficial to the population to be served as the original site.

(c) Contribution to the orderly development of health care facilities and/or services. The applicant should address any potential delays that would be caused by the proposed change of site, and show that any such delays are outweighed by the benefit that will be gained from the change of site by the population to be served.

(5) Certificate of need conditions. In accordance with T.C.A. § 68-11-1609, The Agency, in its discretion, may place such conditions upon a certificate of need it deems appropriate and enforceable to meet the applicable criteria as defined in statute and in these rules.

Authority: *T.C.A. §§ 4-5-202, 68-11-1605, and 68-11-1609.* ***Administrative History:*** *Original rule filed August 31, 2005; effective November 14, 2005.*

CERTIFICATE OF NEED APPLICATION REVIEW

Erlanger Behavioral Health
North Holtzclaw Avenue and Citico Avenue
Chattanooga, TN 37404
June 28, 2016

(Revised August 16, 2016)

The Department of Mental Health and Substance Abuse Services staff have reviewed the application for a Certificate of Need submitted by Erlanger Health System on behalf of Erlanger Behavioral Health, a new LLC, for the construction of a new hospital with 88 psychiatric and chemical dependency beds. In accordance with the rules of the Tennessee Health Services and Development Agency, the Department's analysis consists of the following components: Need, Economic Feasibility; and Contribution to the Orderly Development of Health Care.

This review and analysis has three (3) parts:

- Scope of Project
- Analysis of Need, Economic Feasibility and Contribution to the Orderly Development of Health Care
- Conclusions

1. SCOPE OF PROJECT

Erlanger Health System, a governmental unit of the Chattanooga-Hamilton County Hospital authority, is applying for a Certificate of Need to construct an 88 bed mental hospital with services for inpatients and outpatients and substance abuse in four categories: acute adult, chemical dependency, geriatric and children and youth. The 88 bed hospital includes the transfer of 12 existing geriatric psychiatric beds from the Erlanger North campus (reduces the Erlanger North beds from 57 to 45) and adds 76 new beds. The bed mix will be twenty-four (24) adult psychiatric, twenty-four (24) geriatric psychiatric, eighteen (18) child/adolescent psychiatric and twenty-two (22) adult chemical dependency beds.

The proposed hospital is a joint venture between Erlanger Health System and Acadia Healthcare; the new hospital will be known as Erlanger Behavioral Health, LLC. The proposed Hospital is a 69,000 SF project and will be located at an unaddressed site at the intersection of North Holtzclaw Avenue and Citico Avenue, Chattanooga, Tennessee.

The estimated project cost is $25,112,600. Funding for architecture, design, engineering and construction for this project will be provided by Acadia Healthcare.
Erlanger Behavioral Health, LLC is proposed to serve eighteen (18) Tennessee counties and twelve (12) contiguous counties in Georgia, North Carolina and Alabama for a total of 30 counties. This is the same area currently served by Erlanger Health System.

If approved in CY 2016, Erlanger Behavioral Health expects to initiate services in June, 2018.

2. ANALYSIS

A. NEED

Tennessee's Health Guidelines for Growth sets the population-based estimate for the total need for psychiatric inpatient services at 30 beds per 100,000 general population. These Guidelines do not further stratify those numbers for special populations or age groups. The application of the formula sometimes results in an underestimation of the number of inpatient psychiatric beds needed due to a number of factors: bed utilization, willingness of the provider to accept emergency involuntary admission, the extent to which the provider serves the TennCare population and/or the indigent population, the number of beds designated as "specialty" beds or beds designated for specific diagnostic categories. These factors impact the availability of beds for the general population as well as for specialty populations, depending on how the beds are distributed. Other influencing factors include the number of existing beds in the proposed service area, bed utilization and TDMHSAS' support for community services for people to increase family involvement, utilization of the person's community support system and access to aftercare.

For the analysis for this Application, the JAR's definition of staffed beds is used: the total number of adult and pediatric beds set up, staffed and in use at the end of the reporting period. This number should be less-than or equal-to the number of licensed beds.

Existing Beds: The Applicant indicated that there are 395 existing psychiatric inpatient beds in their Tennessee service area and 7 at a single hospital in Georgia (Hamilton Medical Center) for a total of 402 beds in the service area. However, the list includes Parkridge West Hospital (170 acute beds) that closed on April 4, 2016 and did not include the DeKalb Regional Medical Center in Alabama (18 geriatric psychiatry beds). There are an additional 41 non-hospital based detox beds in the area. Some of the listed hospitals do not designate a specific number of detox or chemical dependency beds but rather include these specialty areas in the adult acute

psychiatric bed count. (See Chart 1. Sources for Chart 1 include both information from the 2014 JAR and report from individual hospitals).

The staffed bed occupancy rate (2014 JAR) of the 3 private hospitals in Chattanooga is 82.8; the occupancy rate for Moccasin Bend Mental Health Institute (MBMHI) is 91.1. Occupancy rates for unique specialty units in the other hospitals in the service area are not available. A breakdown of specialty bed use is not consistently available since hospitals frequently categorize admissions with chemical dependency, detox and geriatric patients to an adult unit.

Chart 1: Current Staffed Beds (Supply) - Tennessee						
Hospital	***Adult Psychiatric (18-64)***	***Chemical Dependency***	***Geropsychiatric***	***Child/ Adolescent***	***Staffed Occupancy***	***Bed Total***
Southern Regional (Winchester)			12		n/a	12
River Park (Jasper) (Warren County)			10		n/a	10
Tennova – Cleveland (formerly Skyridge)	21	9 (detox)			n/a	30
Starr Regional Medical Center			10*		n/a	10
Moccasin Bend Mental Health Institute	150				91.1	150
Parkridge Valley Adult & Senior Services	32	16 (detox and dual dx)			70.9	48
Parkridge Valley Child & Adolescent				108	76.6	108
Erlanger North			12			
Total	**203**	**25**	**44**	**108**		**380**
*Starr has 4 additional beds approved but unimplemented						

Other Detox Beds in Area	
Non-Hospital	***Chemical Dependency***
CADAS	12 detox
Volunteer	17 detox

FOCUS	12 detox
Total	**41**

Other Counties in Service Area

The 2016 population of the service area of the other counties is 578,414 (Nielsen). Two out of state hospitals serve a segment of the identified population: Hamilton Medical Center in Dalton, Georgia reports seven (7) staffed adult psychiatric beds and DeKalb Regional Medical Center in Fort Payne, Alabama reports eighteen (18) staffed geriatric psychiatric beds for a total of twenty-five (25) beds in the out of state hospitals in the service area.

Chart 1A: Service Area Staffed Beds in Out of State Contiguous Counties					
Hospital	***Adult Psychiatric***	***Chemical Dependency***	***Geropsychiatric***	***Child/ Adolescent***	***Bed Total***
Hamilton Medical Center (GA)	7				7
DeKalb Regional Medical Center (AL)			18		18
Total	**7**		**18**		**25**

Population Data

Chart 2: Service Area Population		
Tennessee Counties (18)*		
2016	***2020 (Projected)***	
1,015,247	1,049,445	
Out of State Contiguous Counties**		
County	***2015****	***2016*****
Catoosa County, Georgia	66,050	66,244
Dade County, Georgia	16,264	16,480
Walker County, Georgia	68,066	68,154
Chattooga County, Georgia	24,922	24,450
Fannin County, Georgia	24,303	24,131
Gilmer County, Georgia	29,400	29,086
Gordon County, Georgia	56,574	56,214
Murray County, Georgia	39,565	39,229
Whitfield County, Georgia	104,216	103,211
Cherokee County, North Carolina	27,178	27,512
DeKalb County, Alabama	71,130	70,940
Jackson County, Alabama	52,419	52,763
Total	**580,087**	**578,414**

*2015 Revised UTCBER Population Projection Services
UT Center for Business & Economic Research
Population Projection Data Files, Reassembled by TDOH

**U.S. Census Bureau, Population Division, May 2016
***Nielsen

Population and Need

The Applicant finds a 2016 population of 1,571,392 in the service area with a bed need of 471 and a supply of 402 (Original application and Supplemental Information to TDMHSAS)**.** Their estimation of unmet need for inpatient psychiatric beds is 69. (Applicant's population and bed needs changed depending on version of Supplemental information/original application).

Using the service area population data in Chart 2, we find the Tennessee 2016 service area population to be 1,015,247 with a bed need of 305 and a supply of 380 beds (203 adult acute psychiatric, 25 inpatient detox beds, 44 geriatric psychiatric and 108 child/adolescent). With the 2020 increase of 34,198 to the projected 2016 Tennessee population, the bed need would be 315 (rounded) beds. The Tennessee age related population increase for 0-17 is 1,780; 18-64 is 2,028 and 65+ is 30,390.

Bed Supply and Need (see Chart 3)

The existing bed supply for the Applicant's entire service area is 405 (380+25); the current bed need is 478; using the additional growth increase in the 2020 Tennessee population and in the identified out of state population, the bed need would be 482. (Bed need calculated at 30 beds per 100,000 population).

Chart 3: Population Based Bed Need			
2016	**Population**	**Need**	**Supply**
Tennessee*	1,015,247	305	380
Out of State**	578,414	173.52	25
Total	**1,593,661**	**478**	**405**

2020	**Population**	**Need**
Tennessee*	1,049,445	315
Out of State**	556,975	167
Total	**1,606420**	**482**

*2015 Revised UTCBER Population Projection Services, UT Center for Business & Economic Research, Population Projection Data Files, Reassembled by TDOH
**Nielsen

The bed need based on 2016 projected population in Tennessee supports an oversupply of 75 beds (supply of 380 minus need of 305); projected bed need for 2020 supports a population based need of 315 beds.

Other Needs Data

The Applicant offered additional data (Supplemental Data for TDMHSAS #2) to support the determination of need for chemical dependency and child/adolescent beds (Tennessee does not stratify by specialty but rather uses the standard of 30 psychiatric beds per 100,000 population for all populations). For this purpose, the Applicant used methodology from the 2015 CON rules of the State of Mississippi. That standard requires .14 beds per thousand population for age 18+. The population data used for this calculation was 1,242,681. The cited population for 0-17 was 350,980. Using the Mississippi methodology, the calculations for bed need show a total of 173.9 beds for adult chemical dependency and 193.1 beds required for child/adolescent.

The proposed service area 0-17 population is projected to increase 0.83%; the 18-64 projected population increase is 0.34% and the 65+ population is projected to increase 13.01%.

Using the 30 beds per 100,000 formula, the bed need is 65 child/adolescent beds compared to 108 existing beds. Additionally, for the 18-64 age range, the projected need in 2020 is 180 beds with current supply of 203. The projected bed need in 2020 for adults 65+ is 70 beds. Assuming continuation of the current supply, 26 beds would be needed (current supply is 44 beds)

According to data generated by TDOH, there were 312 Hamilton County and 130 Bradley County outpatient discharges from hospitals in the service area for opioid poisoning in 2015; additionally, there were 582 inpatient discharges from Hamilton County and 178 from Bradley County for the same time period. It is probable that at least some of these individuals would be served in the proposed chemical dependency program.

The Applicant adds that out of 34,853 discharges from the Erlanger Health System (10/14-9/15), around one third, 11,561, had behavioral health issues. 6,468 of those were originally admitted through the Hospital's emergency department (Supplemental #2); an unknown portion of these could be served in the proposed psychiatric beds.

According to TDMHSAS 2015 Crisis Services Data, in the Applicant's Tennessee service area, crisis response teams referred 2,568 individuals for emergency involuntary hospitalization. These referrals were both acute adults and adolescents. These individuals were either served at MBMHI or deferred to another regional mental health institute depending on bed availability.

Although current Tennessee population-based bed need indicates an oversupply of 75 beds, other factors are relevant for consideration. The staffed bed occupancy rates for

Hamilton County mental health hospitals is 82.8% (total occupancy rates for inpatient psychiatric facilities in the service area have increased from 63.9% in 2012 to 74.5% in 2014) and for MBMHI, 91.1% indicating that these facilities are consistently operating at or near full capacity. Parkridge Valley does accept some involuntary admissions but only those with insurance. Erlanger Behavioral Health and MBMHI would be the only hospitals in the area that accept involuntary admissions of uninsured persons. The utilization of existing resources appears to show that the service area could support additional resources.

B. ECONOMIC FEASIBILITY

Ownership and Management

Erlanger Behavioral Health is proposed to be an LLC that is jointly owned by Erlanger Health System (51%) and Acadia Healthcare (49%). The new facility will have its own management team and governing body with some management services supplied by Acadia (equal to 2% of net revenue-Supplemental #2). Erlanger is currently operating a geriatric psychiatry unit, offers outpatient behavioral health at their FQHC sites and has a psychiatry division and LCSWs in the Emergency Department of Erlanger Medical Center to address patients with co-existing medical and behavioral health conditions (Supplemental #2). It does not have a history at operating inpatient acute adult psychiatric, chemical dependency nor child/adolescent psychiatric services. The Applicant has relied on the experience of Acadia to calculate bed mix and program operation and development.

Acadia, according to their website, is a provider of inpatient behavioral healthcare services. Acadia operates 85 behavioral healthcare facilities with 17,100 beds in 39 states, the United Kingdom and Puerto Rico. It provides behavioral healthcare and addiction services in inpatient psychiatric hospitals, residential treatment center, and outpatient clinics, among other settings. Acadia operates 4 facilities and 381 beds in Tennessee: Volunteer Comprehensive Treatment (methadone) in Chattanooga; Trustpoint Hospital (mental health, substance abuse, detox for adults) in Murfreesboro; Village Behavioral Health (residential mental health and substance abuse for teens) in Louisville; and Delta (mental health, substance abuse and detox) in Memphis.

Expected Costs and Alternatives; Revenue and Expense Information

The Applicant estimates the total project cost for the construction of the new 88-bed facility to be $25,112,600 (includes CON filing fee) or approximately $271.30 per square foot which puts the construction cost in the third quartile cost per square foot

of hospital construction cost approved by HSDA during 2012-2014. Other Estimates include:

- Architectural and Engineering fees at $1,632,600
- Site Acquisition and Preparation costs at $2,625,000
- Legal, Administrative, Consultant fees: $50,000
- Construction costs at $18,720,000
- Contingency fund: $1,000,000
- Fixed equipment at $350,000
- Other (Dietary equipment & misc. start-up costs): $690,000

Acadia will fund all costs for architecture, engineering, design and construction necessary for the facility through a $300M revolving line of credit with $135.7 million of availability under the revolving credit facility as of December 31, 2015. Acadia has committed to provide $25M, more or less, to fund design and construction and a $5M credit line for working capital, general corporate purposes and startup expenses. This credit line is proposed to fund any operating shortfalls that may arise during startup of the new hospital. Erlanger Health System will contribute its geriatric psychiatric unit and its Erlanger brand to the project. The Applicant indicates that should Acadia not be able to fund the project, Erlanger Health System has the patients and funds to develop and implement the project. The Applicant submitted an audited financial statement for Erlanger Health System reflecting a current ratio for Erlanger as 2.63 to 1, as of June 30, 2015. A ratio of 1:1 is required to have the minimum amount of assets needed to cover current liabilities. Acadia's cash on hand at 2015 was reported to be $11.215M; Erlanger's cash on hand was reported to be $92.64M. Erlanger Health System would also seek a new partner should Acadia not be able to fund the project.

Project Alternatives

The Applicant considered and rejected a number of alternatives for this project:

- Co-locating with the Erlanger North Hospital: rejected due to topography and inability to accommodate in a functionally efficient manner; required extensive site improvement that produced higher costs;
- Erlanger Medical Center campus: currently available land is earmarked for a new/replacement children's hospital and ambulatory care building;
- Hamilton County Health Department site adjacent to Erlanger Medical Center: alternative required service relocation and replacement increasing project cost. Additional contiguous land will be utilized for street extension;
- Sites owned by city and county which were rejected due to contemplated high density industrial development;

- Not developing the project at all was rejected because of the perception of need.

Projections

Since Erlanger Behavioral Health is a new facility, no historical data was available for projections. A Historical Data Chart was submitted based on historical data for Erlanger Health System. There is not a straight line comparison between the operation of a medical surgical hospital and a mental health hospital although it does represent a starting point for assessment of operation.

The Applicant projected a net loss less capital expenditures in the first year of operation at $1,211,921 but by year 2, a net operating income of $114,438 (Supplemental #2). This was based on the following projections:

Chart 4: Projected Utilization			
	Year 1	**Year 2**	**Year 3**
Admissions	1,071	2,128	
Patient Days	8,798	17,481	
Aver Daily Census	24.1	47.9	56.8
ALOS	8.21	8.21	
Occupancy %	27%	54%	64%

Based on the above admissions, the projected net operating revenue would be:

	Year 1	Year 2
Net Operating Revenue	$4,670,977	$10,951,810
Net Revenue Per Admission	$4,361	$5,146

Note that Year 1 includes the start-up cost and twelve (12) months of expenses, but only ten (10) months of revenue. The first two (2) months of Year 1 are planned for staff training and facility setup and other start-up activities.

Providers of acute psychiatric services in the service area (2014 JAR) list an average net revenue range per inpatient admission from $8,835 to $11,096. The Applicant's projections are less than either of these and may in the future require adjusting of rates and payor mix. The application (page 58) lists the average charge amounts per patient:

Average Gross Charge	$11,206
Average Deduction from Revenue	$ 6,845
Average Net Revenue	$ 4,361

Average Deduction from Revenue	
Medicare	$7,759
TennCare/Medicaid	$12,820
Average Net Revenue	
Medicare	$7,759
TennCare/Medicaid	$7,422

The Applicant also submits the following supplementary information on projected charity care (Supplement to TDMHSAS #2):

Chart 5: Projected Charity Care		
	Year 1	**Year 2**
Total Patient Days	8,798	17,481
Gross Revenue	12,001,800	26,867,331
Average Gross Revenue/PPD	1,364.15	1,536,94
Provision for Charity	293,232	588,873
Total Charity Care Pts	26	47

Assuming the accuracy of all of these projections, a positive operating margin, although slim, would be gained by Year Two.

The Applicant will apply for participation in the Medicare and TennCare programs including BlueCare, TennCare Select and AmeriGroup Community Care programs. Revenue from these sources is estimated to be $7,033,566 with percentage of gross revenue from Medicare at 32.6% and Medicaid, 25.7%. Other revenue sources are projected to be commercial (29.7%), self pay (8.9%) and other (3.1%). The Applicant also recognizes potential for future revenue growth due to expected industrial and business growth in the area.

C. CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE

Erlanger Behavioral Health proposes to serve minorities and individuals with low incomes and uninsured, including TennCare enrollees. It is noted that Erlanger Behavioral Health will be classified as an IMD where the cost of patient care for TennCare enrollees aged 21-64 will be reimbursed using 100 percent state funds with no matching federal funds.

Erlanger Behavioral Health, through its regional development effort, will offer educational services and community outreach program to the entities which have an affiliation with the hospital. Such activities will focus on increasing awareness of signs and symptoms of behavioral health disorders.

The Applicant indicates that public transportation is available for access to services from the Hamilton County area. Patients from rural areas would either be transported by ambulance or care givers. The Applicant plans to accept involuntary admissions.

The Applicant plans to provide mobile assessment services in local hospital Emergency Departments (Supplemental Information to TMHSAS #2). This is a unique service and should facilitate referral to the new facility. Although not addressed in the application, this could also contribute to continuity of care if the assessment service also makes appropriate referrals to a behavioral health provider when hospitalization is not indicated.

The Applicant considers the new hospital a major asset because it will be part of and an expansion of an existing health system and enhance Erlanger Health System's ability to integrate its services within the service area as a safety net provider, trauma center and academic medical center.

To the extent that Erlanger Behavioral Health is broadly accessible to low income and indigent patients, will accept involuntary patients, and will serve TennCare and Medicare patients, it will contribute to the availability of a continuum of psychiatric services.

Staffing and Salaries

Staffing for outpatient, intensive outpatient, partial hospitalization, intake, and crisis assessment will be located in the Needs Assessment Department of the new Hospital and will not be co-mingled with the inpatient units (Supplemental information to TDMHSAS). The Applicant also reports that the staff of the intake and crisis assessment units will provide assessments within the Needs Assessment Department or directly onsite in area hospital Emergency Departments. The ECT Therapy service line will be staffed with contract Internal Medicine Physicians, contract Anesthesiologist, and 3 FTE RN's. This staff is also separate from the inpatient units. The staffing pattern submitted and salary data are for inpatient only.

Staffing rates for the 88 bed facility are cited at 42 daily FTEs in Year 2 and 48 FTEs in Year 3. The program FTEs for Year 2 include 1.6 physician, 1 director of nursing, 11.3 nurses, 31.9 nurse assistants, and 12 social workers. Other FTEs listed by the Applicant include 1 CEO, 1 CFO, 1 COO, 3.2 administrative assistants, 2.4 for billing, 1.4 for accounting and 1.2 for marketing. Total FTEs is projected to be 100.9.

The Applicant provides the following salary data (TDMHSAS has added the THA data for comparison):

Chart 6: Salary Comparison Data

	EHS*	Market Mid-point*	2015 THA Base Rate 50th percentile
Administrative Assistant	18.03	17.84	17.76
Patient Billing	16.38	16.01	13.96
Accounting	29.98	31.93	21.12 (Acct II)
Marketing Manager	53.88	46.21	39.68
Psychiatrist	103.45	102.00	
Psychiatric RN	-	32.75	26.06 (Staff nurse)
Psychiatric nurse assistant	-	14.10	10.70 (BH Tech)
Social worker	27.60	23.09	24.22 (LCSW)
CEO			138.46
CFO			122.88
COO			133.12
Hospital Admin.			121.05
DON			80.54

*Applicant's data; Midpoint data from 2015 Mercer Group Salary Survey reported by Applicant

The staffing pattern submitted by the Applicant does not list any specialty staff such as substance abuse counselors, addictionologists, gerontologists nor children and youth specialists. Although the Applicant's salary data is roughly comparable to other hospitals in the area, it does not address need for professionals that would provide intended specialty services that could impact the salary rate.

The Applicant suggests that pharmacy services may be shared with Erlanger Medical Center with on-site medication distribution at Erlanger Behavioral Health. Laboratory services will be contracted with collection of specimen samples on a scheduled basis and storage in a designated location within the facility (Supplemental Information #2 to TDMHSAS).

The Applicant reports the use of the 12 Step Abstinence Model for the detoxification services with an expected length of stay of 12-15 days. Internal medicine physicians will supervise medical treatment for patients in active withdrawal from any substance. No professional staff with substance abuse specialty are listed by the Applicant.

The Applicant intends to employ interested existing staff of good standing of the geriatric psychiatry unit being moved from Erlanger North to Erlanger Behavioral Health; Acadia has committed to transferring current pay rates and length of service

as well as making economic adjustments for any differences between benefit packages.

Acadia will provide support services as needed for operational oversight such as quality assurance, risk management, information systems and legal (Supplemental information to TDMHSAS).

Based on projected occupancy rate cited by the Applicant, the staffing rate should be adequate. However, the types of professional staff listed do not address the specialty populations the Applicant intends to serve.

Effect on Existing Providers and Resources

The Applicant does not anticipate any negative effect of the proposed construction on the health care system. The Applicant does not expect to have any impact on Moccasin Bend Mental Health Institute (MBMHI) because of the perception that MBMHI serves only individuals with a severe and persistent mental illness. However, MBMHI is not limited to serving such persons but also serves any person who meets involuntary commitment standards. Considering the 91.1 occupancy rate at MBMHI and that Erlanger Behavioral Health will accept involuntary admissions, the admission and occupancy rate of the state hospital could be reduced. If the new facility accepts individuals who require acute psychiatric care without regard to the payor source, and those needing involuntary hospitalization, it should be an asset to the health care system. The current occupancy rates in the service area warrant additional bed options.

Letters of Support or Opposition

One letter of support was received from the Erlanger Chief of Behavioral Health, two from the Chief Executive Officer and Clinical Administrator of Children's Hospital at Erlanger, one from the Senior Vice President, Physician Services at Erlanger Health System, one from the Professor and Interim Dean of UT College of Medicine Chattanooga and one from a community member. Additionally, the Applicant submitted a number of comments from social media in support of the project. Several commentators identified support because of waiting lists at existing mental health resources and/or backups in Emergency Departments awaiting admission to a behavioral health inpatient bed. No letter or comments in opposition were received.

Implementation of State Health Plan

The framework for the State Health Plan is based on the Five Principles for Achieving Better Health that generally address improvement of the health of Tennesseans; allow reasonable access to health care; development of resources to

address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the state's health care system; monitoring for the quality of health care and support of the development, recruitment and retention of a sufficient and quality health care workforce (2013 Annual Report, State of Tennessee Division of Health Planning, page 8).

Erlanger Behavioral Health's application promotes these principles through addition of specialized healthcare for adults seeking mental health or chemical dependency treatment, detoxification and children and adolescents needing mental health treatment. It also proposes to provide access to services to underserved and low income populations, those needing involuntary hospitalization and those with TennCare and/or Medicare. The Applicant also proposes to participate in professional training for behavioral health professionals. Their mobile assessment services are unique to the area and, depending on how the program is developed, could provide a referral source to the hospital and for outpatient services by other providers when hospitalization is unnecessary. The community could also benefit from the Applicant's proposed activities that focus on increasing awareness of signs and symptoms of behavioral health disorders.

Working Relationship with Existing Health Care Providers

Since this is an application for a new facility, there are no transfer agreements in place, no working relationships with existing health care providers and no current participation in the training of students through internships, residencies and other such programs. However the Applicant reports that it has plans to have transfer agreements with its own Erlanger Health System hospitals and with substantially all of the same entities currently in place with Erlanger Medical Center. Further, it anticipates that there will be transfer arrangements specific to behavioral health with a majority of these providers (Supplemental Information to TDMHSAS). It will also have an agreement with MBMHI. The Applicant did not address an agreement with the behavioral health mobile crisis teams in the service area.

Erlanger Behavioral Health plans to negotiate contracts with all managed care organizations in the TennCare program, the Georgia Medicaid program, commercial insurers and other behavioral health plan organizations as construction is completed. The Applicant did not identify the need to assist patients to complete SSI and SSDI applications, TennCare and Medicare applications and applications for the Healthcare Insurance Marketplace, all of which would support continuity of care.

Participation in Training of Students

The Applicant plans to negotiate professional training affiliations for physicians, residents and fellows in its hospital. Consideration will also be given to training

programs for social workers and advanced practice nurses to add to Erlanger Health System's affiliations with colleges and universities offering allied health and related training programs.

Erlanger Health System already provides a location for training of senior medical students through the UT College of Medicine and a number of physicians trained under this program have stayed in the area to work with Erlanger Health System. None of the current residency and fellowship programs include behavioral health specialties. The Applicant expects to continue and perhaps expand this collaboration to graduate medical education and training residency program in psychiatry. The Applicant does not address participation in training in specialty areas such as substance abuse, gerontology, children/adolescent psychiatry or addictionology. Participation in training activities provides an excellent recruitment opportunity.

All counties in the identified Tennessee services area are classified as medically underserved areas and a health professional shortage area according to the Tennessee Department of Health's annual assessment for HRSA. According to Tennessee Nurses Association reports, Tennessee does not currently have a nursing shortage although information is only available statewide and not by county or specialty area. No current assessment of the specific supply of social workers, psychologists, or addiction specialists for the state was identified. The Applicant does not anticipate staff recruitment issues.

The Applicant indicates that it has reviewed and intends to comply with all licensing and certification requirements imposed by applicable statutes and regulations including licensure by the Tennessee Department of Mental Health and Substance Abuse Services. No notice of the intent to apply for licensure has yet been filed with TDMHSAS. The Applicant also intends to seek accreditation from The Joint Commission and certification from CMS.

3. CONCLUSIONS

The Department of Mental Health and Substance Abuse Services recommends the approval of the Certificate of Need for Erlanger Behavioral Health to construct a new building with 88 behavioral health beds located at an unaddressed site at the intersection of North Holtzclaw Avenue and Citico Avenue, Chattanooga, Tennessee.

1. The Guidelines for Growth formula has often proven to underestimate the need for psychiatric beds; that formula projects a current oversupply of beds in Tennessee but an unmet bed need in the Applicant's total service area. Population increases project a slight increased bed need over the next four (4) years in the service area. This project addresses the need to increase the bed supply to accommodate a slight Tennessee population increase but significantly to also accommodate a very high bed utilization

rate in the area.

2. Adequate funding appears to be available from Acadia to cover the cost of construction of the new facility; projected gross operating revenue appears to be sufficient to support the economic feasibility of the project although at a slim margin.

3. The project contributes to the orderly development of health care because it will continue to provide services for people with low income, Medicaid or Medicare enrollees, and those who are uninsured that access healthcare in the service area. To the extent that Erlanger Behavioral Health serves individuals meeting criteria for emergency involuntary hospitalization, the hospital would have a positive impact on the community and the mental health delivery system by making inpatient gero-psychiatric, acute adult, child and adolescent psychiatric and chemical dependency services available at a local level. Other than the one state hospital in the service area, Erlanger Behavioral Health is one of very few that plans to accept emergency involuntary admissions which means that their beds are available to this population for whom there is no less restrictive alternative to emergency involuntary admission to a psychiatric hospital. It is expected that quality of services will be attained because of planned compliance with all applicable regulations and standards including those of TDMHSAS and The Joint Commission and CMS. Erlanger Behavioral Health's commitment to clinical training will promote workforce development in this specialized field.

   In conclusion, TDMHSAS supports the construction of a behavioral health hospital, Erlanger Behavioral Health, with the clinical rationale to provide acute adult inpatient psychiatric, geriatric psychiatric, chemical dependency and children and adolescent services in distinct units designed to address their unique needs. This project will also continue to support services to minorities, low income individuals, TennCare and Medicare enrollees and those in need of emergency involuntary hospitalization.

Response to TDMHSAS

Questions 1

ADDITIONAL INFORMATION

(*For Tennessee Department Of Mental Health & Substance Abuse*)

Erlanger Behavioral Health, LLC

Application To Initiate Psychiatric Services At The
Intersection Of North Holtzclaw Avenue And Citico Avenue,
In Chattanooga, Tennessee, With Establishment
Of An Eighty-Eight (88) Bed Inpatient Hospital
By The Addition Of Seventy-Six (76) Psychiatric Beds
And The Transfer Of Twelve (12) Geriatric-Psychiatric Beds
From *Erlanger North Hospital*

Application Number CN1603-012

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

ADDITIONAL INFORMATION

1.) Please identify the target population to be served in the proposed chemical dependency program including age, types of diagnostic categories and projected lengths of stay. Will detoxification services be offered ? Identify any program models or program descriptions which will be used. Please provide data upon which you projected bed need for this program.

Response

Detoxification services will be offered by *Erlanger Behavioral Health* following the *12 Step Abstinence Model*. Length of stay for this unit is expected to be 12-15 days, and the target population is anyone needing assistance with substance abuse within the range of 18-64 years of age. Internal Medicine physicians will supervise medical treatment for patients in active withdrawal from any substance.

As to specific data upon which projected bed need was based, for the chemical dependency unit, the expertise of Acadia Healthcare in operating behavioral health hospitals was relied upon. Based on this experience, it is expected that the hospital should have a substance abuse component of approximately 20-25% of the total bed capacity … twenty-two (22) of the proposed eighty-eight bed facility.

Additionally, with the first supplemental information which was submitted, a total of 3,956 patients from MDC 20, the substance abuse medical diagnostic category, were identified as being discharged from Tennessee hospitals where the patient originated from the Tennessee counties in the defined service area. Therefore, with a 12-15 day ALOS for substance abuse, it is reasonable to conclude that the twenty-two (22) bed unit proposed in this project will be sustainable in the long term.

2.) Indicate the staffing pattern for each proposed program (including partial and outpatient) and identify where there is a shared staff across programs. Will any staff be shared with Erlanger Health system or Acadia ?

Response

The staff for *Erlanger Behavioral Health* will be dedicated to patient care and services for that facility. *Acadia* will provide support services as needed for operational oversight such as quality assurance, risk management, information systems and legal. There is a possibility that there could be some sharing of pharmacy services with *Erlanger Medical Center*. However, it is not anticipated that there would be any sharing of direct patient care staff, such as nursing.

As requested, the staffing for each unit at *Erlanger Behavioral Health* is below.

	No. Of Beds	== Avg. Daily Census ==== Year 1	Year 2	Year 3	Staffing For Year 2	Staffing For Year 3
Adult Psychiatric Unit	24.0	4.0	10.0	13.0	RN-5, MHT-3	RN-6, MHT-4
Gero Psychiatric Unit	24.0	12.0	18.0	20.0	RN-6, MHT-8	RN-6, MHT-10
Child & Adolescent Unit	18.0	4.0	10.0	11.0	RN-5, MHT-3	RN-5, MHT-3
Chemical Dependency Unit	22.0	4.1	9.9	12.8	RN-5, MHT-3	RN-6, MHT-4
Partial Hospitalization / Outpatient					RN-2, MHT-2	RN-2, MHT-2
Total	88.0	24.1	47.9	56.8	RN-23, MHT-19	RN-25, MHT-23

3.) If not explained in supplemental material, please complete the sentence on the top of page 35 (03/14/16 CON application) that begins "Because MBMHI treats those who are severely and persistently mentally ill, it is not expected that this project will impact it's services as that target patient population is ."

Response

The sentence on page 35 was originally intended to distinguish the type of patients which *Erlanger Behavioral Health* would see with those of *MBMHI*, the sentence would be completed as follows …

> "Because *MBMHI* treats those who are severely and persistently mentally ill, it is not expected that this project will impact it's services as that target patient population is not the same clientele that *Erlanger Behavioral Health* will treat."

4.) You have included projected utilization data for years 1 and 2. Please project by type of program and add a

year 3.

Response

As requested, the projected utilization table with occupancy by unit, has been revised to add data for year 3.

	No. Of Beds	==== Year 1 ==== ADC	Unit Occ.	==== Year 2 ==== ADC	Unit Occ.	==== Year 3 ==== ADC	Unit Occ.
Adult Psychiatric Unit	24.0	4.0	16.7%	10.0	41.7%	13.0	54.2%
Gero Psychiatric Unit	24.0	12.0	50.0%	18.0	75.0%	20.0	83.3%
Child & Adolescent Unit	18.0	4.0	22.2%	10.0	55.6%	11.0	61.1%
Chemical Dependency Unit	22.0	4.1	18.6%	9.9	45.0%	12.8	58.2%
Total	88.0	24.1		47.9		56.8	
Total Occupancy			27.4%		54.4%		64.5%

It should be noted that these utilization rates are generally conservative and actual utilization could be higher than projected.

5.) Please submit utilization and occupancy data for the gero-psychiatric program you currently operate.

Response

As requested, the utilization and occupancy information for the *Geriatric Psychiatric Unit* and *Erlanger North Hospital* is below.

	Erlanger North -- Geriatric Psychiatric Unit				
	No. Of Beds	Admits	Pt. Days	ALOS	Occ.
FY 2014-15	12.0	238	3,531	14.8	80.6%
FY 2013-14	12.0	262	3,628	13.8	82.8%
FY 2012-13	12.0	281	3,761	13.4	85.9%

6.) Please identify in your list of patient transfer agreements those that would be specific to this project. Other than a new agreement with MBMHI as specified in supplemental information, list other

agreements that will be solicited.

Response

As noted, we provided a list of patient transfer agreements currently in place for *Erlanger Medical Center* and it is expected that *Erlanger Behavioral Health* will have agreements with substantially all of these entities. In addition to the *MBMHI* agreement, it is anticipated that all potential referral sources within the defined service will have a transfer agreement (i.e.-hospitals, nursing homes, etc.). However, since it is in the early stage of development, it is difficult to say precisely what facilities will execute transfer agreements with *Erlanger Behavioral Health*.

7.) List your referral sources both for admission and discharge.

Response

As noted in question six (6), we have provided the list of patient transfer agreements which *Erlanger Medical Center* currently has and it is anticipated that there will be agreements with substantially all of these entities. However, since it is in the early stage of development, it is difficult to say precisely what facilities will execute transfer agreements with *Erlanger Behavioral Health*.

Pertaining to discharged patients which are transferred, discharge planning staff will work closely with the receiving facility to ensure patient stability and continuity of care. For patients which are discharged home and/or to the care of another behavioral health provider, outpatient follow-up services will be available to coordinate follow-up care.

8.) As part of your discussion of need, you emphasized disparities in behavioral healthcare for "Blacks, Latinos and Asian Americans." How will you address this ?

Response

It is anticipated that the regional development effort will include offering educational services and community outreach programs to the entities which have an affiliation with *Erlanger Behavioral Health*. The educational programming and community outreach to these underserved populations will focus on increasing awareness of signs and symptoms of behavioral health disorders. Further, information will be provided to make direct contact with *Erlanger Behavioral Health*.

Additionally, in the tradition of *Erlanger Health System*, members of these vulnerable and underserved populations will be treated without consideration of ability to pay for services which may be needed. Further, a culture of diversity will be promoted to ensure appropriate care for those in need.

9.) Other than Psychiatry, please list the other professional training affiliation planned.

Response

Other than Psychiatry, *Erlanger Behavioral Health* anticipates additional professional training affiliations. Consideration could be given to training programs for Advanced Practice Nurses in the Psychiatry/Mental Health specialty, as well as Licensed Clinical Social Work.

10.) You list public transportation as mode of access. How will patients from rural counties access your services ?

Response

While the proposed location for *Erlanger Behavioral Health* is accessible via public transportation in Chattanooga, patients from the rural counties will most likely be transported by a family member, legal guardian or other care giver. However, in emergency or crisis situations, the patient will most likely be transported by ambulance.

	Total Pop. CY 2016	Total Pop. CY 2020	0-17 Pop. CY 2016	0-17 Pop. CY 2020	18+ Pop. CY 2016	18+ Pop. CY 2020	65+ Pop. CY 2016	65+ Pop. CY 2020	18-64 Pop. CY 2016	18-64 Pop. CY 2020
Hamilton County, TN	356,156	368,666	77,582	80,402	278,574	288,264	61,073	69,752	217,501	218,512
Bradley County, TN	105,549	109,706	23,615	23,841	81,934	85,865	17,879	20,381	64,055	65,484
Marion County, TN	28,585	28,633	5,911	5,703	22,674	22,930	5,763	6,584	16,911	16,346
Grundy County, TN	13,470	13,263	2,882	2,695	10,588	10,568	3,021	3,339	7,567	7,229
Sequatchie County, TN	15,835	16,943	3,407	3,501	12,428	13,442	3,195	3,896	9,233	9,546
Bledsoe County, TN	13,273	13,481	2,601	2,546	10,672	10,935	2,628	2,955	8,044	7,980
Rhea County, TN	33,934	35,216	7,677	7,606	26,257	27,610	6,589	7,571	19,668	20,039
Meigs County, TN	12,221	12,462	2,352	2,220	9,869	10,242	2,677	3,151	7,192	7,091
McMinn County, TN	54,449	55,724	11,636	11,592	42,813	44,132	11,089	12,650	31,724	31,482
Polk County, TN	17,442	17,812	3,571	3,524	13,871	14,288	3,680	4,134	10,191	10,154
Dade County, GA	16,480	16,571	3,262	3,118	13,218	13,453	2,889	3,221	10,329	10,232
Walker County, GA	68,154	68,576	15,052	14,548	53,102	54,028	11,988	13,424	41,114	40,604
Catoosa County, GA	66,244	68,063	15,258	14,909	50,986	53,154	10,789	12,212	40,197	40,942
DeKalb County, AL	70,940	71,111	17,601	17,268	53,339	53,843	11,494	12,596	41,845	41,247
Jackson County, AL	52,763	52,717	11,212	10,768	41,551	41,949	10,220	11,288	31,331	30,661
Chatooga County, GA	24,450	23,811	5,419	5,168	19,031	18,643	4,157	4,459	14,874	14,184
Fannin County, GA	24,131	24,727	4,311	4,263	19,820	20,464	6,155	6,823	13,665	13,641
Gilmer County, GA	29,086	29,911	6,041	6,048	23,045	23,863	6,372	7,148	16,673	16,715
Gordon County, GA	56,214	57,299	14,354	14,197	41,860	43,102	7,781	8,801	34,079	34,301
Murray County, GA	39,229	39,724	10,001	10,020	29,228	29,704	5,300	5,989	23,928	23,715
Whitfield County, GA	103,211	104,465	28,274	27,927	74,937	76,538	13,297	14,593	61,640	61,945
Cherokee County, NC	27,512	27,844	4,842	4,694	22,670	23,150	7,364	8,032	15,306	15,118
Coffee County, TN	55,932	57,865	13,140	13,331	42,792	44,534	10,225	11,573	32,567	32,961
Cumberland County, TN	61,910	65,575	10,702	10,767	51,208	54,808	19,871	23,106	31,337	31,702
Franklin County, TN	42,097	42,681	8,610	8,158	33,487	34,523	8,752	9,972	24,735	24,551
Loudon County, TN	54,261	57,923	10,069	10,311	44,192	47,612	15,089	17,908	29,103	29,704
Monroe County, TN	47,980	50,062	10,186	10,083	37,794	39,979	10,398	12,384	27,396	27,595
Roane County, TN	55,630	56,301	10,683	10,324	44,947	45,977	12,670	14,509	32,277	31,468
Van Buren County, TN	5,651	5,686	1,056	992	4,595	4,694	1,313	1,554	3,282	3,140
Warren County, TN	40,872	41,446	9,673	9,537	31,199	31,909	7,350	8,233	23,849	23,676
Total >>>>	1,593,661	1,634,264	350,980	350,061	1,242,681	1,284,203	301,068	342,238	941,613	941,965

Tennessee Population Estimates 2016 and 2020 *

	Population Estimate 2016			Population Estimate 2020			% Increase	
	Total	0-17	% 0-17	Total	0-17	% 0-17	0-17	Total
Tennessee	6,812,005	1,570,687	23.1%	7,108,031	1,614,001	22.7%	2.8%	4.3%
Anderson	77,667	16,377	21.1%	79,061	16,289	20.6%	-0.5%	1.8%
Bedford	50,005	13,024	26.0%	53,334	13,664	25.6%	4.9%	6.7%
Benton	16,672	3,098	18.6%	16,741	2,977	17.8%	-3.9%	0.4%
Bledsoe	13,273	2,601	19.6%	13,481	2,546	18.9%	-2.1%	1.6%
Blount	133,236	27,783	20.9%	139,725	27,984	20.0%	0.7%	4.9%
Bradley	105,549	23,615	22.4%	109,706	23,841	21.7%	1.0%	3.9%
Campbell	41,464	8,592	20.7%	41,787	8,328	19.9%	-3.1%	0.8%
Cannon	14,464	2,947	20.4%	14,838	2,882	19.4%	-2.2%	2.6%
Carroll	28,380	6,107	21.5%	28,207	5,927	21.0%	-2.9%	-0.6%
Carter	58,139	11,220	19.3%	58,375	10,917	18.7%	-2.7%	0.4%
Cheatham	40,798	9,234	22.6%	41,692	8,975	21.5%	-2.8%	2.2%
Chester	18,260	3,959	21.7%	18,978	3,880	20.4%	-2.0%	3.9%
Claiborne	33,800	6,591	19.5%	34,713	6,406	18.5%	-2.8%	2.7%
Clay	7,879	1,550	19.7%	7,875	1,525	19.4%	-1.6%	-0.1%
Cocke	36,976	7,475	20.2%	37,663	7,315	19.4%	-2.1%	1.9%
Coffee	55,932	13,140	23.5%	57,865	13,331	23.0%	1.5%	3.5%
Crockett	14,884	3,564	23.9%	15,080	3,554	23.6%	-0.3%	1.3%
Cumberland	61,910	10,702	17.3%	65,575	10,767	16.4%	0.6%	5.9%
Davidson	680,427	161,733	23.8%	714,756	175,647	24.6%	8.6%	5.0%
Decatur	11,963	2,413	20.2%	12,077	2,372	19.6%	-1.7%	1.0%
DeKalb	19,644	4,309	21.9%	20,206	4,309	21.3%	0.0%	2.9%
Dickson	53,684	12,723	23.7%	56,210	12,939	23.0%	1.7%	4.7%
Dyer	39,306	9,295	23.6%	39,872	9,309	23.3%	0.2%	1.4%
Fayette	44,637	9,670	21.7%	48,510	10,014	20.6%	3.6%	8.7%
Fentress	18,823	3,996	21.2%	19,309	3,869	20.0%	-3.2%	2.6%
Franklin	42,097	8,610	20.5%	42,681	8,158	19.1%	-5.2%	1.4%
Gibson	51,394	12,355	24.0%	52,438	12,397	23.6%	0.3%	2.0%
Giles	29,743	6,231	20.9%	29,817	6,061	20.3%	-2.7%	0.2%
Grainger	23,890	4,933	20.6%	24,577	4,900	19.9%	-0.7%	2.9%
Greene	72,512	14,291	19.7%	74,656	14,109	18.9%	-1.3%	3.0%
Grundy	13,470	2,882	21.4%	13,263	2,695	20.3%	-6.5%	-1.5%
Hamblen	65,332	15,145	23.2%	67,028	15,442	23.0%	2.0%	2.6%
Hamilton	356,156	77,582	21.8%	368,666	80,402	21.8%	3.6%	3.5%
Hancock	6,951	1,406	20.2%	7,007	1,366	19.5%	-2.8%	0.8%
Hardeman	27,283	5,383	19.7%	27,278	5,143	18.9%	-4.5%	0.0%
Hardin	26,557	5,353	20.2%	26,783	5,204	19.4%	-2.8%	0.9%
Hawkins	58,771	12,149	20.7%	59,784	11,739	19.6%	-3.4%	1.7%
Haywood	18,410	4,386	23.8%	18,128	4,178	23.0%	-4.7%	-1.5%
Henderson	29,349	6,825	23.3%	30,298	6,898	22.8%	1.1%	3.2%
Henry	33,439	6,896	20.6%	34,055	6,777	19.9%	-1.7%	1.8%
Hickman	26,351	5,429	20.6%	27,363	5,398	19.7%	-0.6%	3.8%
Houston	8,869	1,962	22.1%	9,157	1,947	21.3%	-0.8%	3.2%
Humphreys	18,987	4,079	21.5%	19,185	3,968	20.7%	-2.7%	1.0%
Jackson	12,120	2,189	18.1%	12,375	2,097	16.9%	-4.2%	2.1%
Jefferson	55,714	11,564	20.8%	58,372	11,612	19.9%	0.4%	4.8%
Johnson	18,793	3,251	17.3%	19,112	3,144	16.5%	-3.3%	1.7%
Knox	466,345	103,173	22.1%	488,993	107,822	22.0%	4.5%	4.9%
Lake	8,299	1,250	15.1%	8,579	1,187	13.8%	-5.0%	3.4%
Lauderdale	28,658	6,653	23.2%	29,186	6,580	22.5%	-1.1%	1.8%
Lawrence	43,164	10,354	24.0%	43,849	10,184	23.2%	-1.6%	1.6%
Lewis	12,752	2,775	21.8%	13,072	2,701	20.7%	-2.7%	2.5%
Lincoln	34,695	7,755	22.4%	35,469	7,672	21.6%	-1.1%	2.2%

Tennessee Population Estimates 2016 and 2020 *

	Population Estimate 2016			Population Estimate 2020			% Increase	
	Total	0-17	% 0-17	Total	0-17	% 0-17	0-17	Total
Loudon	54,261	10,069	18.6%	57,923	10,311	17.8%	2.4%	6.7%
McMinn	54,449	11,636	21.4%	55,724	11,592	20.8%	-0.4%	2.3%
McNairy	27,179	5,986	22.0%	27,760	5,860	21.1%	-2.1%	2.1%
Macon	23,453	5,496	23.4%	24,202	5,501	22.7%	0.1%	3.2%
Madison	103,234	24,762	24.0%	106,352	25,201	23.7%	1.8%	3.0%
Marion	28,585	5,911	20.7%	28,633	5,703	19.9%	-3.5%	0.2%
Marshall	33,105	7,738	23.4%	34,648	7,815	22.6%	1.0%	4.7%
Maury	88,337	21,006	23.8%	92,944	21,695	23.3%	3.3%	5.2%
Meigs	12,221	2,352	19.2%	12,462	2,220	17.8%	-5.6%	2.0%
Monroe	47,980	10,186	21.2%	50,062	10,083	20.1%	-1.0%	4.3%
Montgomery	201,598	58,428	29.0%	221,620	65,402	29.5%	11.9%	9.9%
Moore	6,795	1,345	19.8%	7,056	1,302	18.5%	-3.2%	3.8%
Morgan	23,402	4,476	19.1%	24,288	4,367	18.0%	-2.4%	3.8%
Obion	31,692	6,842	21.6%	31,559	6,619	21.0%	-3.3%	-0.4%
Overton	23,460	5,130	21.9%	24,291	5,112	21.0%	-0.4%	3.5%
Perry	8,266	1,739	21.0%	8,466	1,724	20.4%	-0.9%	2.4%
Pickett	5,205	917	17.6%	5,264	821	15.6%	-10.5%	1.1%
Polk	17,442	3,571	20.5%	17,812	3,524	19.8%	-1.3%	2.1%
Putnam	79,658	17,350	21.8%	84,087	18,241	21.7%	5.1%	5.6%
Rhea	33,934	7,677	22.6%	35,216	7,606	21.6%	-0.9%	3.8%
Roane	55,630	10,683	19.2%	56,301	10,324	18.3%	-3.4%	1.2%
Robertson	73,796	18,399	24.9%	78,659	19,171	24.4%	4.2%	6.6%
Rutherford	318,638	81,906	25.7%	357,615	90,675	25.4%	10.7%	12.2%
Scott	22,878	5,508	24.1%	23,224	5,419	23.3%	-1.6%	1.5%
Sequatchie	15,835	3,407	21.5%	16,943	3,501	20.7%	2.8%	7.0%
Sevier	101,144	20,872	20.6%	108,468	21,792	20.1%	4.4%	7.2%
Shelby	959,361	247,503	25.8%	981,022	252,312	25.7%	1.9%	2.3%
Smith	20,207	4,553	22.5%	20,833	4,485	21.5%	-1.5%	3.1%
Stewart	14,011	2,889	20.6%	14,402	2,784	19.3%	-3.6%	2.8%
Sullivan	158,938	31,084	19.6%	159,749	30,524	19.1%	-1.8%	0.5%
Sumner	178,730	42,713	23.9%	190,261	43,775	23.0%	2.5%	6.5%
Tipton	67,250	16,904	25.1%	71,196	17,157	24.1%	1.5%	5.9%
Trousdale	8,402	1,898	22.6%	8,739	1,910	21.9%	0.6%	4.0%
Unicoi	18,847	3,620	19.2%	19,150	3,535	18.5%	-2.3%	1.6%
Union	19,903	4,488	22.5%	20,320	4,428	21.8%	-1.3%	2.1%
VanBuren	5,651	1,056	18.7%	5,686	992	17.4%	-6.1%	0.6%
Warren	40,872	9,673	23.7%	41,446	9,537	23.0%	-1.4%	1.4%
Washington	133,817	26,740	20.0%	140,905	27,808	19.7%	4.0%	5.3%
Wayne	17,428	3,112	17.9%	17,642	2,975	16.9%	-4.4%	1.2%
Weakley	36,066	7,043	19.5%	36,360	6,975	19.2%	-1.0%	0.8%
White	27,519	5,768	21.0%	28,541	5,726	20.1%	-0.7%	3.7%
Williamson	215,859	57,346	26.6%	234,832	57,200	24.4%	-0.3%	8.8%
Wilson	129,094	30,326	23.5%	138,561	30,949	22.3%	2.1%	7.3%

* 2015 Revised UTCBER Population Projection Series.

Source: The University of Tennessee Center for Business and Economic Research Population Projection Data Files, Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment.
Note: These data will not match the University of Tennessee Data exactly due to rounding.

Tennessee Population Estimates 2016 and 2020 *

	Population Estimate 2016			Population Estimate 2020			% Increase	
	Total	18+	%18+	Total	18+	%18+	18+	Total
Tennessee	6,812,005	5,241,318	76.9%	7,108,031	5,494,030	77.3%	4.8%	4.3%
Anderson	77,667	61,290	78.9%	79,061	62,772	79.4%	2.4%	1.8%
Bedford	50,005	36,981	74.0%	53,334	39,670	74.4%	7.3%	6.7%
Benton	16,672	13,574	81.4%	16,741	13,764	82.2%	1.4%	0.4%
Bledsoe	13,273	10,672	80.4%	13,481	10,935	81.1%	2.5%	1.6%
Blount	133,236	105,453	79.1%	139,725	111,741	80.0%	6.0%	4.9%
Bradley	105,549	81,934	77.6%	109,706	85,865	78.3%	4.8%	3.9%
Campbell	41,464	32,872	79.3%	41,787	33,459	80.1%	1.8%	0.8%
Cannon	14,464	11,517	79.6%	14,838	11,956	80.6%	3.8%	2.6%
Carroll	28,380	22,273	78.5%	28,207	22,280	79.0%	0.0%	-0.6%
Carter	58,139	46,919	80.7%	58,375	47,458	81.3%	1.1%	0.4%
Cheatham	40,798	31,564	77.4%	41,692	32,717	78.5%	3.7%	2.2%
Chester	18,260	14,301	78.3%	18,978	15,098	79.6%	5.6%	3.9%
Claiborne	33,800	27,209	80.5%	34,713	28,307	81.5%	4.0%	2.7%
Clay	7,879	6,329	80.3%	7,875	6,350	80.6%	0.3%	-0.1%
Cocke	36,976	29,501	79.8%	37,663	30,348	80.6%	2.9%	1.9%
Coffee	55,932	42,792	76.5%	57,865	44,534	77.0%	4.1%	3.5%
Crockett	14,884	11,320	76.1%	15,080	11,526	76.4%	1.8%	1.3%
Cumberland	61,910	51,208	82.7%	65,575	54,808	83.6%	7.0%	5.9%
Davidson	680,427	518,694	76.2%	714,756	539,109	75.4%	3.9%	5.0%
Decatur	11,963	9,550	79.8%	12,077	9,705	80.4%	1.6%	1.0%
DeKalb	19,644	15,335	78.1%	20,206	15,897	78.7%	3.7%	2.9%
Dickson	53,684	40,961	76.3%	56,210	43,271	77.0%	5.6%	4.7%
Dyer	39,306	30,011	76.4%	39,872	30,563	76.7%	1.8%	1.4%
Fayette	44,637	34,967	78.3%	48,510	38,496	79.4%	10.1%	8.7%
Fentress	18,823	14,827	78.8%	19,309	15,440	80.0%	4.1%	2.6%
Franklin	42,097	33,487	79.5%	42,681	34,523	80.9%	3.1%	1.4%
Gibson	51,394	39,039	76.0%	52,438	40,041	76.4%	2.6%	2.0%
Giles	29,743	23,512	79.1%	29,817	23,756	79.7%	1.0%	0.2%
Grainger	23,890	18,957	79.4%	24,577	19,677	80.1%	3.8%	2.9%
Greene	72,512	58,221	80.3%	74,656	60,547	81.1%	4.0%	3.0%
Grundy	13,470	10,588	78.6%	13,263	10,568	79.7%	-0.2%	-1.5%
Hamblen	65,332	50,187	76.8%	67,028	51,586	77.0%	2.8%	2.6%
Hamilton	356,156	278,574	78.2%	368,666	288,264	78.2%	3.5%	3.5%
Hancock	6,951	5,545	79.8%	7,007	5,641	80.5%	1.7%	0.8%
Hardeman	27,283	21,900	80.3%	27,278	22,135	81.1%	1.1%	0.0%
Hardin	26,557	21,204	79.8%	26,783	21,579	80.6%	1.8%	0.9%
Hawkins	58,771	46,622	79.3%	59,784	48,045	80.4%	3.1%	1.7%
Haywood	18,410	14,024	76.2%	18,128	13,950	77.0%	-0.5%	-1.5%
Henderson	29,349	22,524	76.7%	30,298	23,400	77.2%	3.9%	3.2%
Henry	33,439	26,543	79.4%	34,055	27,278	80.1%	2.8%	1.8%
Hickman	26,351	20,922	79.4%	27,363	21,965	80.3%	5.0%	3.8%
Houston	8,869	6,907	77.9%	9,157	7,210	78.7%	4.4%	3.2%
Humphreys	18,987	14,908	78.5%	19,185	15,217	79.3%	2.1%	1.0%
Jackson	12,120	9,931	81.9%	12,375	10,278	83.1%	3.5%	2.1%
Jefferson	55,714	44,150	79.2%	58,372	46,760	80.1%	5.9%	4.8%
Johnson	18,793	15,542	82.7%	19,112	15,968	83.5%	2.7%	1.7%
Knox	466,345	363,172	77.9%	488,993	381,171	78.0%	5.0%	4.9%
Lake	8,299	7,049	84.9%	8,579	7,392	86.2%	4.9%	3.4%
Lauderdale	28,658	22,005	76.8%	29,186	22,606	77.5%	2.7%	1.8%
Lawrence	43,164	32,810	76.0%	43,849	33,665	76.8%	2.6%	1.6%
Lewis	12,752	9,977	78.2%	13,072	10,371	79.3%	3.9%	2.5%
Lincoln	34,695	26,940	77.6%	35,469	27,797	78.4%	3.2%	2.2%

Tennessee Population Estimates 2016 and 2020 *

	Population Estimate 2016			Population Estimate 2020			% Increase	
	Total	18+	%18+	Total	18+	%18+	18+	Total
Loudon	54,261	44,192	81.4%	57,923	47,612	82.2%	7.7%	6.7%
McMinn	54,449	42,813	78.6%	55,724	44,132	79.2%	3.1%	2.3%
McNairy	27,179	21,193	78.0%	27,760	21,900	78.9%	3.3%	2.1%
Macon	23,453	17,957	76.6%	24,202	18,701	77.3%	4.1%	3.2%
Madison	103,234	78,472	76.0%	106,352	81,151	76.3%	3.4%	3.0%
Marion	28,585	22,674	79.3%	28,633	22,930	80.1%	1.1%	0.2%
Marshall	33,105	25,367	76.6%	34,648	26,833	77.4%	5.8%	4.7%
Maury	88,337	67,331	76.2%	92,944	71,249	76.7%	5.8%	5.2%
Meigs	12,221	9,869	80.8%	12,462	10,242	82.2%	3.8%	2.0%
Monroe	47,980	37,794	78.8%	50,062	39,979	79.9%	5.8%	4.3%
Montgomery	201,598	143,170	71.0%	221,620	156,218	70.5%	9.1%	9.9%
Moore	6,795	5,450	80.2%	7,056	5,754	81.5%	5.6%	3.8%
Morgan	23,402	18,926	80.9%	24,288	19,921	82.0%	5.3%	3.8%
Obion	31,692	24,850	78.4%	31,559	24,940	79.0%	0.4%	-0.4%
Overton	23,460	18,330	78.1%	24,291	19,179	79.0%	4.6%	3.5%
Perry	8,266	6,527	79.0%	8,466	6,742	79.6%	3.3%	2.4%
Pickett	5,205	4,288	82.4%	5,264	4,443	84.4%	3.6%	1.1%
Polk	17,442	13,871	79.5%	17,812	14,288	80.2%	3.0%	2.1%
Putnam	79,658	62,308	78.2%	84,087	65,846	78.3%	5.7%	5.6%
Rhea	33,934	26,257	77.4%	35,216	27,610	78.4%	5.2%	3.8%
Roane	55,630	44,947	80.8%	56,301	45,977	81.7%	2.3%	1.2%
Robertson	73,796	55,397	75.1%	78,659	59,488	75.6%	7.4%	6.6%
Rutherford	318,638	236,732	74.3%	357,615	266,940	74.6%	12.8%	12.2%
Scott	22,878	17,370	75.9%	23,224	17,805	76.7%	2.5%	1.5%
Sequatchie	15,835	12,428	78.5%	16,943	13,442	79.3%	8.2%	7.0%
Sevier	101,144	80,272	79.4%	108,468	86,676	79.9%	8.0%	7.2%
Shelby	959,361	711,858	74.2%	981,022	728,710	74.3%	2.4%	2.3%
Smith	20,207	15,654	77.5%	20,833	16,348	78.5%	4.4%	3.1%
Stewart	14,011	11,122	79.4%	14,402	11,618	80.7%	4.5%	2.8%
Sullivan	158,938	127,854	80.4%	159,749	129,225	80.9%	1.1%	0.5%
Sumner	178,730	136,017	76.1%	190,261	146,486	77.0%	7.7%	6.5%
Tipton	67,250	50,346	74.9%	71,196	54,039	75.9%	7.3%	5.9%
Trousdale	8,402	6,504	77.4%	8,739	6,829	78.1%	5.0%	4.0%
Unicoi	18,847	15,227	80.8%	19,150	15,615	81.5%	2.5%	1.6%
Union	19,903	15,415	77.5%	20,320	15,892	78.2%	3.1%	2.1%
VanBuren	5,651	4,595	81.3%	5,686	4,694	82.6%	2.2%	0.6%
Warren	40,872	31,199	76.3%	41,446	31,909	77.0%	2.3%	1.4%
Washington	133,817	107,077	80.0%	140,905	113,097	80.3%	5.6%	5.3%
Wayne	17,428	14,316	82.1%	17,642	14,667	83.1%	2.5%	1.2%
Weakley	36,066	29,023	80.5%	36,360	29,385	80.8%	1.2%	0.8%
White	27,519	21,751	79.0%	28,541	22,815	79.9%	4.9%	3.7%
Williamson	215,859	158,513	73.4%	234,832	177,632	75.6%	12.1%	8.8%
Wilson	129,094	98,768	76.5%	138,561	107,612	77.7%	9.0%	7.3%

* 2015 Revised UTCBER Population Projection Series.

Source: The University of Tennessee Center for Business and Economic Research Population Projection Data Files, Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment.
Note: These data will not match the University of Tennessee Data exactly due to rounding.

Tennessee Population Estimates 2016 and 2020 *

	Population Estimate 2016			Population Estimate 2020			% Increase	
	Total	65+	%65+	Total	65+	%65+	65+	Total
Tennessee	6,812,005	1,091,516	16.0%	7,108,031	1,266,295	17.8%	16.0%	4.3%
Anderson	77,667	15,608	20.1%	79,061	17,490	22.1%	12.1%	1.8%
Bedford	50,005	7,664	15.3%	53,334	8,957	16.8%	16.9%	6.7%
Benton	16,672	4,115	24.7%	16,741	4,568	27.3%	11.0%	0.4%
Bledsoe	13,273	2,628	19.8%	13,481	2,955	21.9%	12.4%	1.6%
Blount	133,236	26,259	19.7%	139,725	30,754	22.0%	17.1%	4.9%
Bradley	105,549	17,879	16.9%	109,706	20,381	18.6%	14.0%	3.9%
Campbell	41,464	8,645	20.8%	41,787	9,698	23.2%	12.2%	0.8%
Cannon	14,464	2,767	19.1%	14,838	3,187	21.5%	15.2%	2.6%
Carroll	28,380	5,992	21.1%	28,207	6,501	23.0%	8.5%	-0.6%
Carter	58,139	12,124	20.9%	58,375	13,475	23.1%	11.1%	0.4%
Cheatham	40,798	5,931	14.5%	41,692	7,175	17.2%	21.0%	2.2%
Chester	18,260	3,171	17.4%	18,978	3,590	18.9%	13.2%	3.9%
Claiborne	33,800	6,774	20.0%	34,713	7,876	22.7%	16.3%	2.7%
Clay	7,879	1,948	24.7%	7,875	2,147	27.3%	10.2%	-0.1%
Cocke	36,976	7,811	21.1%	37,663	8,986	23.9%	15.0%	1.9%
Coffee	55,932	10,225	18.3%	57,865	11,573	20.0%	13.2%	3.5%
Crockett	14,884	2,808	18.9%	15,080	3,079	20.4%	9.7%	1.3%
Cumberland	61,910	19,871	32.1%	65,575	23,106	35.2%	16.3%	5.9%
Davidson	680,427	77,571	11.4%	714,756	88,314	12.4%	13.8%	5.0%
Decatur	11,963	2,930	24.5%	12,077	3,263	27.0%	11.4%	1.0%
DeKalb	19,644	3,772	19.2%	20,206	4,386	21.7%	16.3%	2.9%
Dickson	53,684	8,497	15.8%	56,210	10,001	17.8%	17.7%	4.7%
Dyer	39,306	6,853	17.4%	39,872	7,637	19.2%	11.4%	1.4%
Fayette	44,637	8,731	19.6%	48,510	11,171	23.0%	27.9%	8.7%
Fentress	18,823	4,092	21.7%	19,309	4,787	24.8%	17.0%	2.6%
Franklin	42,097	8,752	20.8%	42,681	9,972	23.4%	13.9%	1.4%
Gibson	51,394	9,391	18.3%	52,438	10,255	19.6%	9.2%	2.0%
Giles	29,743	5,965	20.1%	29,817	6,751	22.6%	13.2%	0.2%
Grainger	23,890	4,951	20.7%	24,577	5,763	23.4%	16.4%	2.9%
Greene	72,512	15,550	21.4%	74,656	17,790	23.8%	14.4%	3.0%
Grundy	13,470	3,021	22.4%	13,263	3,339	25.2%	10.5%	-1.5%
Hamblen	65,332	12,215	18.7%	67,028	13,432	20.0%	10.0%	2.6%
Hamilton	356,156	61,073	17.1%	368,666	69,752	18.9%	14.2%	3.5%
Hancock	6,951	1,470	21.1%	7,007	1,679	24.0%	14.2%	0.8%
Hardeman	27,283	4,636	17.0%	27,278	5,171	19.0%	11.5%	0.0%
Hardin	26,557	5,990	22.6%	26,783	6,681	24.9%	11.5%	0.9%
Hawkins	58,771	12,112	20.6%	59,784	13,883	23.2%	14.6%	1.7%
Haywood	18,410	3,077	16.7%	18,128	3,644	20.1%	18.4%	-1.5%
Henderson	29,349	5,237	17.8%	30,298	5,959	19.7%	13.8%	3.2%
Henry	33,439	7,928	23.7%	34,055	8,959	26.3%	13.0%	1.8%
Hickman	26,351	4,407	16.7%	27,363	5,222	19.1%	18.5%	3.8%
Houston	8,869	1,854	20.9%	9,157	2,134	23.3%	15.1%	3.2%
Humphreys	18,987	3,879	20.4%	19,185	4,384	22.9%	13.0%	1.0%
Jackson	12,120	2,748	22.7%	12,375	3,203	25.9%	16.6%	2.1%
Jefferson	55,714	11,400	20.5%	58,372	13,331	22.8%	16.9%	4.8%
Johnson	18,793	4,060	21.6%	19,112	4,512	23.6%	11.1%	1.7%
Knox	466,345	70,360	15.1%	488,993	80,979	16.6%	15.1%	4.9%
Lake	8,299	1,280	15.4%	8,579	1,399	16.3%	9.3%	3.4%
Lauderdale	28,658	4,084	14.3%	29,186	4,578	15.7%	12.1%	1.8%
Lawrence	43,164	8,159	18.9%	43,849	9,151	20.9%	12.2%	1.6%
Lewis	12,752	2,603	20.4%	13,072	3,050	23.3%	17.2%	2.5%
Lincoln	34,695	6,725	19.4%	35,469	7,655	21.6%	13.8%	2.2%

Tennessee Population Estimates 2016 and 2020 *

	Population Estimate 2016			Population Estimate 2020			% Increase	
	Total	65+	%65+	Total	65+	%65+	65+	Total
Loudon	54,261	15,089	27.8%	57,923	17,908	30.9%	18.7%	6.7%
McMinn	54,449	11,089	20.4%	55,724	12,650	22.7%	14.1%	2.3%
McNairy	27,179	5,630	20.7%	27,760	6,328	22.8%	12.4%	2.1%
Macon	23,453	4,023	17.2%	24,202	4,656	19.2%	15.7%	3.2%
Madison	103,234	16,281	15.8%	106,352	18,943	17.8%	16.4%	3.0%
Marion	28,585	5,763	20.2%	28,633	6,584	23.0%	14.2%	0.2%
Marshall	33,105	5,421	16.4%	34,648	6,566	19.0%	21.1%	4.7%
Maury	88,337	14,276	16.2%	92,944	17,359	18.7%	21.6%	5.2%
Meigs	12,221	2,677	21.9%	12,462	3,151	25.3%	17.7%	2.0%
Monroe	47,980	10,398	21.7%	50,062	12,384	24.7%	19.1%	4.3%
Montgomery	201,598	18,531	9.2%	221,620	22,487	10.1%	21.3%	9.9%
Moore	6,795	1,488	21.9%	7,056	1,704	24.1%	14.5%	3.8%
Morgan	23,402	3,960	16.9%	24,288	4,605	19.0%	16.3%	3.8%
Obion	31,692	6,336	20.0%	31,559	6,897	21.9%	8.9%	-0.4%
Overton	23,460	4,853	20.7%	24,291	5,597	23.0%	15.3%	3.5%
Perry	8,266	1,907	23.1%	8,466	2,157	25.5%	13.1%	2.4%
Pickett	5,205	1,515	29.1%	5,264	1,731	32.9%	14.3%	1.1%
Polk	17,442	3,680	21.1%	17,812	4,134	23.2%	12.3%	2.1%
Putnam	79,658	13,677	17.2%	84,087	15,795	18.8%	15.5%	5.6%
Rhea	33,934	6,589	19.4%	35,216	7,571	21.5%	14.9%	3.8%
Roane	55,630	12,670	22.8%	56,301	14,509	25.8%	14.5%	1.2%
Robertson	73,796	10,629	14.4%	78,659	12,957	16.5%	21.9%	6.6%
Rutherford	318,638	31,869	10.0%	357,615	40,458	11.3%	27.0%	12.2%
Scott	22,878	3,787	16.6%	23,224	4,263	18.4%	12.6%	1.5%
Sequatchie	15,835	3,195	20.2%	16,943	3,896	23.0%	21.9%	7.0%
Sevier	101,144	19,374	19.2%	108,468	23,251	21.4%	20.0%	7.2%
Shelby	959,361	116,834	12.2%	981,022	135,234	13.8%	15.7%	2.3%
Smith	20,207	3,395	16.8%	20,833	3,985	19.1%	17.4%	3.1%
Stewart	14,011	2,883	20.6%	14,402	3,357	23.3%	16.4%	2.8%
Sullivan	158,938	34,510	21.7%	159,749	38,067	23.8%	10.3%	0.5%
Sumner	178,730	27,496	15.4%	190,261	32,919	17.3%	19.7%	6.5%
Tipton	67,250	9,132	13.6%	71,196	11,044	15.5%	20.9%	5.9%
Trousdale	8,402	1,355	16.1%	8,739	1,585	18.1%	17.0%	4.0%
Unicoi	18,847	4,491	23.8%	19,150	5,086	26.6%	13.2%	1.6%
Union	19,903	3,562	17.9%	20,320	4,173	20.5%	17.2%	2.1%
VanBuren	5,651	1,313	23.2%	5,686	1,554	27.3%	18.4%	0.6%
Warren	40,872	7,350	18.0%	41,446	8,233	19.9%	12.0%	1.4%
Washington	133,817	24,231	18.1%	140,905	28,137	20.0%	16.1%	5.3%
Wayne	17,428	3,254	18.7%	17,642	3,576	20.3%	9.9%	1.2%
Weakley	36,066	6,404	17.8%	36,360	7,119	19.6%	11.2%	0.8%
White	27,519	5,806	21.1%	28,541	6,751	23.7%	16.3%	3.7%
Williamson	215,859	27,267	12.6%	234,832	34,838	14.8%	27.8%	8.8%
Wilson	129,094	19,933	15.4%	138,561	24,411	17.6%	22.5%	7.3%

* 2015 Revised UTCBER Population Projection Series.

Source: The University of Tennessee Center for Business and Economic Research Population Projection Data Files, Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment.
Note: These data will not match the University of Tennessee Data exactly due to rounding.

June 19, 2012

William West, Esquire
Baker Donelson
211 Commerce Street. 800
Nashville, TN 37201

RE: Staff Determination Letter No. 2012-SDL-011
Erlanger Bledsoe Free Standing ED

Dear Mr. West:

You have inquired as to why this office has determined that a certificate of need ["CON"] would be required for Erlanger Bledsoe Hospital in Bledsoe County to establish a free-standing emergency department in Sequatchie County that would be owned and operated as an off-campus department of the hospital. We find no authority for considering such a project as other than the establishment of another hospital, for which a CON would be required. T.C.A. §68-11-1607(a)(1). Emergency medical services are part and parcel of a hospital itself, and are specifically delineated as hospital services in Tenn. Rules & Regs., Chapter 1200-8-1. Free-standing emergency departments are themselves acute-care hospitals, with both diagnostic services and multiple treatment rooms (general-purpose, trauma, cardiac, orthopedic, isolation) anticipating upwards of tens of thousands of patient visits annually arriving by ambulance and drive-in. By law, emergency departments must accept all emergent patients, including extremely serious (trauma, etc.) patients, 24 hours each day, as opposed to providing ancillary services to less distressed patients in an office setting. Life-threatening conditions requiring stabilization and transfer by ambulance to a full-service facility are not only anticipated, but invited.

The State Health Planning Division of the Department of Finance and Administration is currently preparing guidelines for free-standing emergency department applications to be included in the State Health Plan. Recent CON applications for the establishment of satellite emergency facilities have included Wellmont Emergency Care and Diagnostic Center at Boone's Creek (which would have established a satellite ED for

obtain a CON before establishing a free-standing emergency department in Red Bank or Signal Mountain, even if the cost could be kept below $5 million. The same would apply were Memorial Hospital to consider a free-standing emergency department in Ooltewah.

This determination is based upon the facts as presented. Should these facts change, this determination would also be subject to change.

Sincerely,

J. B. C

James B. Christoffersen
General Counsel

WILLIAM WEST, SHAREHOLDER
Direct Dial: 615.726.5561
Direct Fax: 615.744.5561
E-Mail Address: bwest@bakerdonelson.com

May 25, 2012

Jim Cristoffersen, Esq.
General Counsel
Tennessee Health Services & Development Agency
500 Deaderick Street
Suite 850
Nashville, TN 37243

Via E-Mail

Re: Request for Staff Advice on the Following Issue - Whether a Certificate of Need is Required for Erlanger Bledsoe Hospital, in Bledsoe County, to Establish a Satellite Emergency Department in Sequatchie County as an Extension of its Emergency Department at Erlanger Bledsoe, if none of the events which require the grant of a Certificate of Need occur

Dear Jim:

As you know, we represent Erlanger Bledsoe Hospital in Bledsoe County, Tennessee. Pursuant to our recent discussions, Erlanger Bledsoe Hospital has requested that I write to you seeking written staff advice in response to the issue raised above. As you know from our discussions, Erlanger Bledsoe Hospital in Bledsoe County, Tennessee, desires to establish a satellite emergency department in Sequatchie County as an extension of the emergency department at Erlanger Bledsoe Hospital. Currently there are no hospitals licensed or existing in Sequatchie County, Tennessee. Erlanger Bledsoe Hospital would also manage the county EMS service in Sequatchie County from that same location if it is permitted to go forward with this project.

Erlanger Bledsoe Hospital has been designated by CMS as a critical access hospital. Pursuant to this designation, it has inquired of CMS as to whether it could carry out the steps outlined above to establish a provider-based off-site emergency department location. The response of CMS was that it was permissible for Erlanger Bledsoe Hospital to do so. A copy of

establish this branch emergency department in Sequatchie County is less than $1,000,000. Therefore the capital expenditure threshold for requiring a Certificate of Need is not a concern.

Furthermore, Erlanger Bledsoe Hospital would not be establishing any type of health care institution in carrying out this proposed action. Erlanger Bledsoe Hospital is an existing and licensed hospital in Pikeville, Tennessee; it is therefore empowered by TCA Section 68-11-209 (f) to "provide outpatient diagnostic and therapeutic services at location other than the hospital's main campus without obtaining a waiver" from the Licensing Board. It is also statutorily empowered by TCA Section 7-57-502 to carry out such actions in counties such as Bledsoe and Sequatchie counties.

In carrying out this proposed project, Erlanger Bledsoe Hospital does not propose to change its licensed hospital bed complement or the location of any of its licensed beds. Therefore the CON requirement in TCA Section 68-11-1607 is not implicated.

Similarly, by carrying out this project, Erlanger Bledsoe Hospital does not propose to initiate any of the health care services delineated in TCA Section 68-11-1607 (a) (4) at the proposed site in Sequatchie County or elsewhere as part of this project. Erlanger Bledsoe Hospital does not propose through this project to change its own location; it is merely adding a remote site for delivery of outpatient services in Sequatchie County.

In light of the foregoing facts, Erlanger Bledsoe Hospital believes that no Certificate of Need should be required for this project establishing a branch of its emergency department in Sequatchie County, Tennessee. On its behalf, we are requesting staff advice from the HSDA staff as to whether this conclusion that no CON is required for this project is correct. If you need any additional information or documents, please do not hesitate to contact me. Thank you for your cooperation.

BAKER, DONELSON, BEARMAN,
CALDWELL & BERKOWITZ, PC

Bill

William West

WW:srs

cc: Joe Winick

N WHW 891060 v1
0-0 05/25/2012

Ms. Ms. Stephanie Boynton, Administrator
Erlanger Bledsoe Hospital
71 Wheelertown Avenue, Box 699
Pikeville, Tennessee 37367

RE: Review of Criteria for Provider Based ER Request

Dear Ms. Boynton:

We acknowledge receipt of your request for verification of the lesser distance due to secondary road requirements for the hospital's proposed provider based off-site emergency department location. We have reviewed your documentation in support of your claim. The determination below is a preliminary determination that will expire one year from the date of this correspondence. If you apply for a provider based off-site hospital emergency department designation after the expiration date, you must again provide documentation showing that you meet the criteria at 42 CFR 485.610(c). Please note that this determination relates to the secondary roads criteria only and to none of the other CAH provider based requirements. Additionally, the application must be accompanied by official Tennessee Department of Transportation verification of secondary road designation of the roads/highways identified in your request.

Based on the documentation complied by your hospital and presented to us for review, we find that your hospital **MEETS** the secondary roads criteria at 42 CFR 485.610(c).

If you have questions, please contact Joe Ann Hollingsworth at (404) 562-7510.

Sincerely,

Sandra M. Pace
Associate Regional Administrator
Division of Survey and Certification

Cc: State Agency

Ex. A

Response to TDMHSAS

Questions 2

ADDITIONAL INFORMATION *(No. 2)*

(For Tennessee Department Of Mental Health & Substance Abuse)

Erlanger Behavioral Health, LLC

Application To Initiate Psychiatric Services At The
Intersection Of North Holtzclaw Avenue And Citico Avenue,
In Chattanooga, Tennessee, With Establishment
Of An Eighty-Eight (88) Bed Inpatient Hospital
By The Addition Of Seventy-Six (76) Psychiatric Beds
And The Transfer Of Twelve (12) Geriatric-Psychiatric Beds
From *Erlanger North Hospital*

Application Number CN1603-012

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

ADDITIONAL INFORMATION

1.) Provide the methodology for the projection of need for 22 chemical dependency beds and 18 child and adolescent beds.

Response

It is noted that this question was asked in the first request for additional information from the *Tennessee Dept. of Mental Health* pertaining to the chemical dependency unit, and the second part of the question pertaining to the child/adolescent unit is new.

As to specific data upon which projected bed need was based, for the chemical dependency unit and also for the Child/Adolescent unit, the expertise of *Acadia Healthcare* in operating behavioral health hospitals was relied upon. Based on this experience, it is expected that the substance abuse unit and the child/adolescent unit should be approximately 20-25% of the total bed capacity. With this thought in mind for the proposed eighty-eight (88) bed hospital, twenty two (22) beds are allocated to the chemical dependency unit and eighteen (18) beds are allocated to the child/adolescent unit; this equals 25% and 20%, respectively. Further, as a full service behavioral health hospital, it is generally understood that to maintain efficiencies within such a facility, a full range of services should be offered.

While the *State of Tennessee* does not include quantitative criteria for determination of need specifically for chemical dependency and child/adolescent beds, we utilized a methodology from the CON rules of the *State of Mississippi*.[1] Specifically, for adult chemical dependency beds, *Mississippi* requires .14 beds per thousand population age 18+. For child/adolescent beds, Mississippi requires .55 beds per thousand population age 0-17. For CY 2016 in the defined service area for *Erlanger Behavioral Health* there is a total of 1,242,681 population age 18+, and a total of 350,980 population age 0-17. With this data and methodology, the calculations for bed need show a total of 173.9 beds required for adult chemical dependency (.14 x

1 *Mississippi State Health Plan - FY 2015.* Chapter 3, Section 106.03.02, page 22. Internet address ... http://msdh.ms.gov/msdhsite/_static/19,0,184,665.html.

1,242) and 193.1 beds required for child/adolescent (.55 x 351).

With this data, the bed need calculation for these service lines, is as follows.

	Est. Beds Required	Current Supply	Est. Need	Proposed Bed Mix
Child / Adolescent Beds - 2016	193	108	85	18
Adult Chemical Dependency Beds - 2016	174	16	158	22
Total	367	124	243	40

Current Supply

(1) Child / adolescent beds are at Parkridge Valley Hospital, Chattanooga, TN.

(2) Adult chemical dependency beds are at Park Ridge Valley Hospital, Chattanooga, TN.

Please note that the bed need calculation on page 34 of the CON application is based simply on the Tennessee standard of 30 beds per 100,000 population in the service area. Whereas, the methodology shown above is based on the specific service lines.

Additionally, we have attached a copy of a new report published by the Treatment Advocacy Center in June, 2016, titled "*Going, Going, Gone - Trends & Consequences Of Eliminating State Psychiatric Beds, 2016*". This report highlights the significant need for additional behavioral health resources all over the country, with Tennessee ranked 40th out of 50 states for state hospital mental health beds per 100,000 population.[2] Further, even when including private hospital mental health beds, the total number of beds in Tennessee per 100,000 population is 8.5 compared to the national average of 11.7.[3]

Certain findings of the report indicate that …

1.) Of the 11.7 beds per 100,000 population, roughly half were available to civil psychiatric patients - people who had not committed crimes.

2.) Of the 11.7 beds per 100,000 population, the other half were occupied by forensic patients admitted to the hospital via the criminal justice system. In two states, Hawaii and Missouri, all of them were.

3.) "Boarding" psychiatric patients in emergency rooms while waiting for beds somewhere in the psychiatric inpatient system was virtually universal.

4.) Those states without long forensic bed waits often have

2 See *Table 2* of this report, p. 14. Internet address … http://www.tacreports.org/storage/documents/going-going-gone.pdf.

3 See *Table 3* of this report, p. 20.

avoided them by diverting civil beds to forensic uses, leading to longer waits in the ER's where the civil patients accumulate.

2.) Please clarify the information on the projected availability of charity care by completing the following chart.

Applicant's Projected Charity Care

Projected Financial Performance	Year 1	Year 2
Total Patient Days	8,798	17,481
Gross Revenue		
Average Gross Revenue/PPD *(per patient day)*		
Provision for Charity		
Total Charity Care Patients		

Response

The charity care gross revenue is estimated at $ 293,232 in year 1 and $ 606,563 in year 2. As requested, the table has been completed below.

Applicant's Projected Charity Care

Projected Financial Performance	Year 1	Year 2
Total Patient Days	8,798	17,481
Gross Revenue	$ 12,001,800	$ 26,867,331
Average Gross Revenue/PPD *(per patient day)*	$ 1,364.15	$ 1,536.94

Provision for Charity	$ 293,232	$ 588,873
Total Charity Care Patients	26	47

3.) The application indicates that Erlanger Behavioral Health will be providing outpatient and intensive outpatient and partial hospitalization, crisis assessment and intake and ECT. Please list staffing of these programs by type and number, whether this staff will be shared with any other programs, especially inpatient programs, any age (adult, child/adolescent) or practice specialties. Also include physicians or advance practice nurses who will practice in these programs but will not specifically be on staff.

Response

The staffing for the programs identified will be as follows.

Outpatient / Intensive Outpatient / Partial Hospitalization

These services will be provided by qualified and licensed mental health professionals, and will increase according to need to meet all regulatory and accreditation guidelines. During the first year of operation, the budget anticipates one (1) MD as needed on a contract basis, 1 FTE RN, 2 FTE Licensed Social Work Therapist for each service line. These staff will not be co-mingled with the inpatient units of care staffing.

Intake / Crisis Assessment

These services will be provided within the Needs Assessment Department of the new Hospital. This department will be staffed with Qualified and Licensed Mental Health Professionals and staffing will increase in according to need, meeting all regulatory and accreditation guidelines. This service line has the flexibility to provide assessments within the Needs Assessment Department or also has mobility to provide assessment services directly onsite in area Hospital

Emergency Departments. These staff will not be co-mingled with the inpatient units of care staffing.

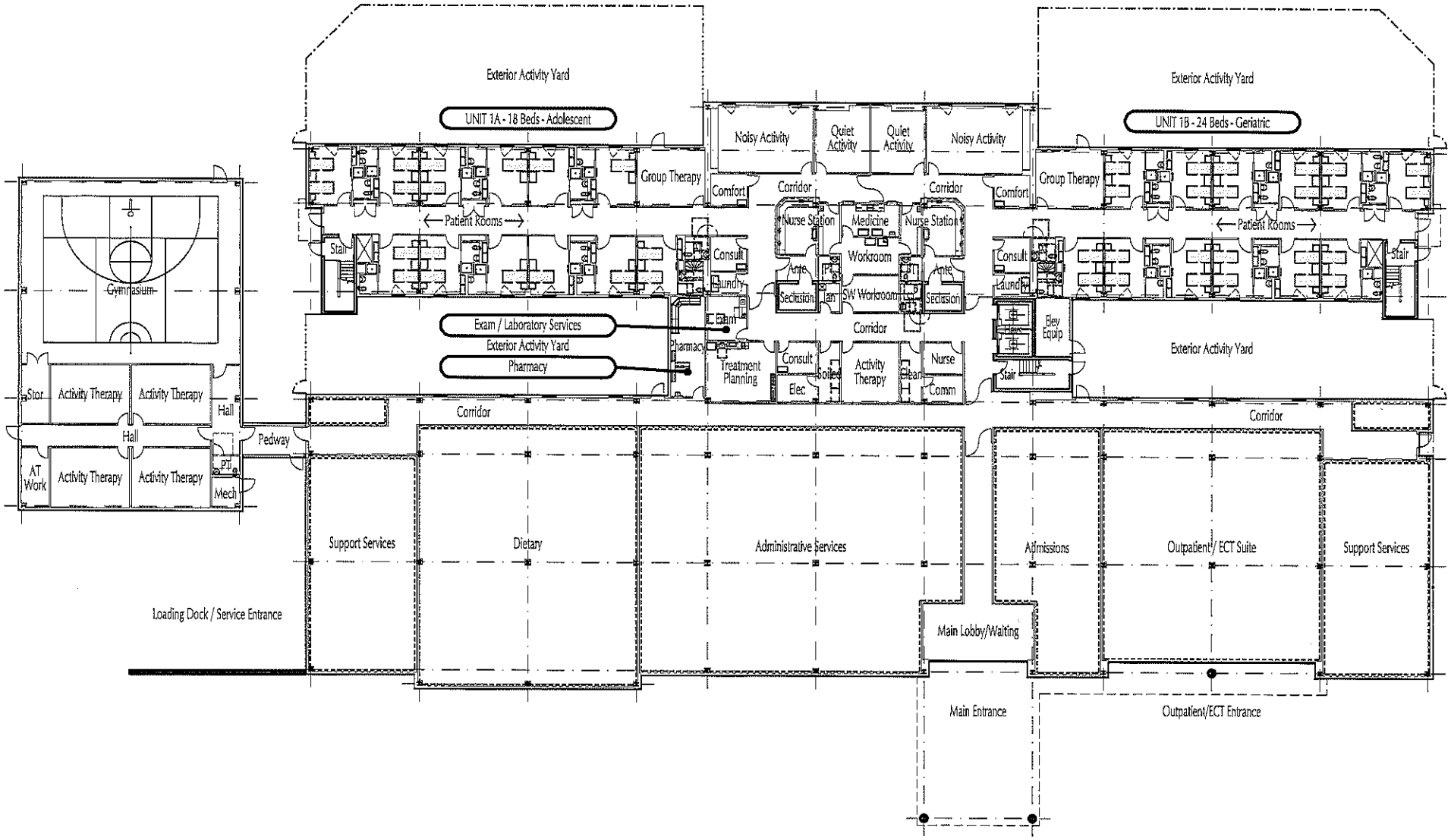
ECT Therapy

This service line will be staffed to meet all regulatory and accreditation guidelines. It will be staffed with contract Internal Medicine Physicians, contract Anesthesiology, and 3 FTE RN's. These staff will not be co-mingled with inpatient units of care staffing.

4.) Please indicate your plan for and/or location of pharmacy and laboratory services. If either will be on site, submit a revised floor plan that reflects the location.

Response

Pharmacy space within the facility is shown on the revised floor plan attached to this additional information, as requested. As to Laboratory space, there will be a designated location within the facility for placement of specimen samples. A contract laboratory service will collect specimen samples on a scheduled basis.



AREA SUMMARY	
New Building Area - First Floor	50,900 sf
New Building Area - Second Floor	18,100 sf
TOTAL NEW BUILDING AREA	69,000 sf

NORTH

GRAPHIC SCALE

0' 20' 40' 80'

CONCEPTUAL FIRST FLOOR PLAN

SEE GRAPHIC SCALE

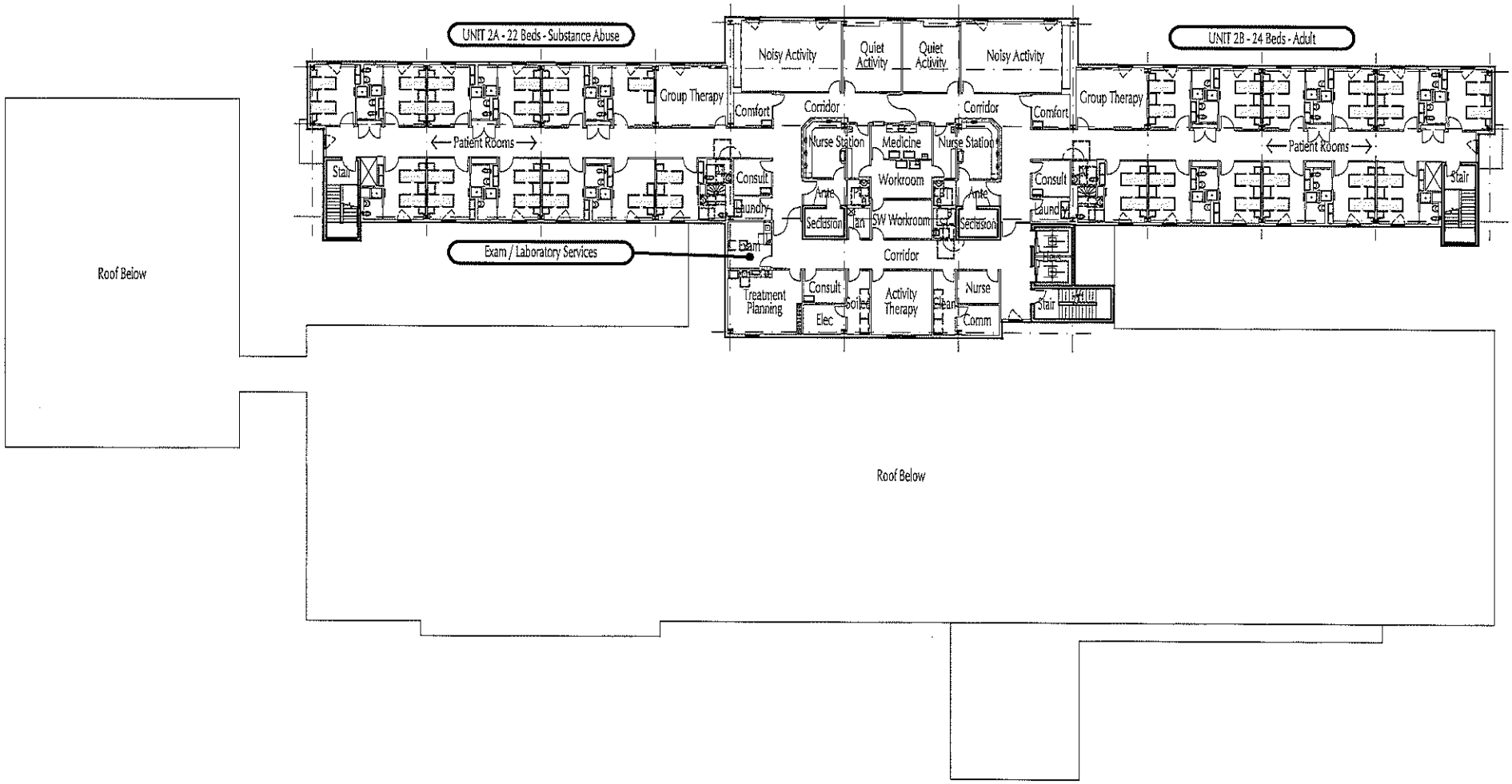
NEW BEHAVIORAL HEALTH HOSPITAL
ERLANGER BEHAVIORAL HEALTH, LLC
CHATTANOOGA, TENNESSEE

CO01-01

AHC1504

14 MARCH 2016

STENGEL-HILL ARCHITECTURE
618 WEST MAIN STREET LOUISVILLE, KENTUCKY 40202 502.893.1878 502.893.1876 fax



AREA SUMMARY	
New Building Area - First Floor	50,900 sf
New Building Area - Second Floor	18,100 sf
TOTAL NEW BUILDING AREA	69,000 sf

NORTH

GRAPHIC SCALE

0' 20' 40' 80'

CONCEPTUAL SECOND FLOOR PLAN

SEE GRAPHIC SCALE

NEW BEHAVIORAL HEALTH HOSPITAL
ERLANGER BEHAVIORAL HEALTH, LLC
CHATTANOOGA, TENNESSEE

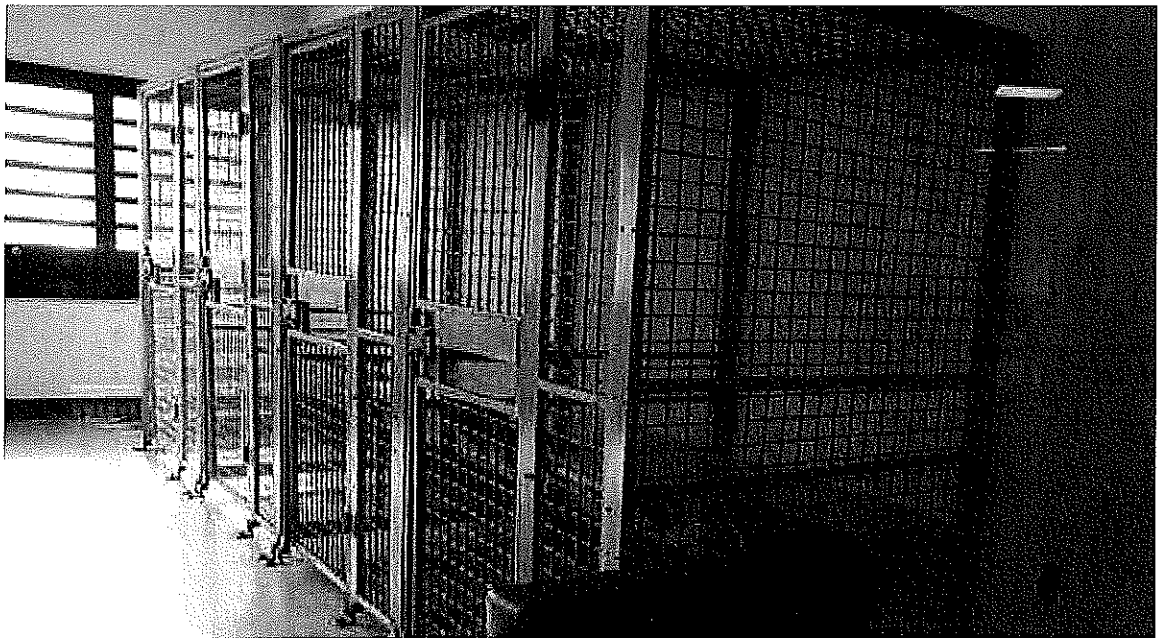
CO01-02

AHC1504

14 MARCH 2016

STENGEL-HILL ARCHITECTURE
613 WEST MAIN STREET LOUISVILLE, KENTUCKY 40202 502.893.1875 502.893.1876 fax

Going, Going, Going Gone



Trends and Consequences of Eliminating State Psychiatric Beds, 2016

A REPORT FROM THE
OFFICE OF RESEARCH
& PUBLIC AFFAIRS

Going, Going, Gone

TRENDS AND CONSEQUENCES OF ELIMINATING STATE PSYCHIATRIC BEDS, 2016

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Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds, 2016, was developed with generous funding from the Val A. Browning Foundation.

June 2016

Online at TACReports.org/going-going-gone

EXECUTIVE SUMMARY

The number of state hospital beds that remain to serve the nation's most ill and potentially dangerous psychiatric patients has fallen to its lowest level on record, setting off a domino effect of unmet need coast to coast. Largely reserved for those individuals considered unsuccessfully treated and/or too dangerous for other health care settings, state hospitals today are the last resort of the mental health system. When there are no beds for them, people who can't be treated elsewhere instead cycle through other institutions or live on the streets. They crowd into emergency rooms and languish behind bars, waiting for beds to open. Some become violent or, more often, the victims of violence. They grow sicker and die. The personal and public costs are incalculable.

Ideally, people with serious mental illness never become psychiatry's equivalent of ICU patients; they receive timely and effective treatment long before they are critically ill. But a complete and reliable continuum of mental health care does not exist in the United States, and available mental health resources are oriented toward patients without serious mental illness. Because many individuals with the most severe psychiatric diseases are unable or unwilling to accept treatment, and some do not respond to treatment, there continue to be individuals—a growing number of people in a country with a growing population—who require the intensive, specialized services hospitals provide.

Those beds are going, going, gone.

The Treatment Advocacy Center in the first quarter of 2016 surveyed the 50 U.S. states and District of Columbia to determine how many state hospital beds remain and whom they serve. We found the following:

- 37,559 staffed beds remain in state hospitals. Adjusted for population growth, this represents a 17% reduction in the bed population since 2010, when 43,318 beds remained, and a 96.5% drop from peak hospital numbers in the 1950s.[1]
- 11.7 beds remain per 100,000 people. This means there are fewer state hospital beds per capita than at any time since before the nation stopped criminalizing mental illness in the 1850s.[2]

Key State Hospital Bed Trends, 1955-2016

YEAR	NATIONWIDE	PER 100,00 POPULATION+	AS A PERCENTAGE OF HISTORICAL PEAK*
2016			
37,559	Total state hospital beds	11.7	3.5%
19,958	Civil beds in state hospitals	6.2	*
17,601	Forensic patients in state hospitals	5.5	*
2010			
43,318	Total state hospital beds	14.1	4.2%
2005			
50,509	Total state hospital beds	16.8	5.0%
1955			
558,922	Total state hospital beds	337.0	

+ Adjusted for the growth in U.S. population
* 1955 data are not available.

- The United States ranks 29th of 34 Organization for Economic Cooperation and Development (OECD) countries. Even with all the psychiatric beds outside state hospitals included, the U.S. had only 37% of the OECD average psychiatric bed population of 68 beds per 100,000 people.[3]
- Nearly 50% of remaining beds—about 5.5 out of the 11.7—were occupied by forensic patients charged with or convicted of crimes.
- Forensic bed demand is exploding. Colorado alone saw a 500% increase in hospital referrals for pretrial competency evaluations for criminal offenders from 2004 to 2013.[4]
- State spending reflects the forensic shift. In the past 25 years, the percentage of state hospital budgets spent for forensic treatment has quadrupled.[5] It continues to rise.
- Despite this historic shift, a majority of states maintain wait lists for their forensic beds, and some lists are months long.[6]
- As more beds are diverted to the forensic population, fewer beds are left for people who haven't committed crimes. "Boarding" patients in mental health crisis to wait in loud, chaotic hospital emergency rooms has become virtually universal as the number of beds for non-offenders has shrunk.[7]
- A growing number of states are resorting to hospital beds behind bars for criminal offenders—psychiatric treatment facilities operated by corrections systems instead of mental health departments. New Hampshire even sends selected civil patients there.

"The mentally ill who have nowhere to go and find little sympathy from those around them often land hard in emergency rooms, county jails and city streets. The lucky ones find homes with family. The unlucky ones show up in the morgue."

Liz Szabo
"A Man-Made Disaster: A Mental Health System Drowning from Neglect"
USA Today (May 12, 2014)

The closing of state-operated psychiatric beds—a trend known as "deinstitutionalization"—has been ongoing in Western democracies since the mid-20th century. The United States is considered its leader, having started earlier and reduced beds more drastically than others. The trend was the result of financial incentives, new psychiatric medications and policies driven by the ideal that every patient would be better off in a small community setting than in a larger facility. The ideal, sound as it may have been, was incompletely realized. The hospitals closed, but community-based clinics did not replace them, or opened and later were defunded and closed. In many small communities, the clinics were often not viable to begin with. Meanwhile, the functions the hospitals once performed for people severely disabled by mental illness—treatment, structure, shelter—were lost, and the people who needed those functions were "transinstitutionalized" to other large settings, such as jails and prisons.[8]

Yet the march toward extinguishing state beds continues. *Going, Going, Gone* is the Treatment Advocacy Center's fourth survey of state hospital beds in eight years. Each reported double-digit bed losses, and there's no sign the next survey will be any different until no beds are left to count. Behind the scenes of the bed shortage, gravely ill and suffering people compete for the inpatient beds that remain. Typically the battle is between civil and forensic patients, but a state official in Connecticut told us children and adolescents in psychiatric crisis are backing up in ERs because juvenile psychiatric beds are being diverted to adults. The reality that an immeasurable number of people with treatable diseases only get treatment when they get sick enough to commit crimes that send them to jail and then to a forensic bed should be a source of national shame and outcry for reform.

Reducing emergency room boarding, jail bed waits and the steep price tags that come with these results of bed shortages requires reducing bed demand, increasing bed supply or both. As part of this survey, the Treatment Advocacy Center analyzed bed trends in 25 sample states to identify public policies and practices that hold some promise in altering the bed equation. The following recommendations are based on our findings and a review of research in the field.

RECOMMENDATIONS

1. **Determine how many psychiatric beds are necessary to meet inpatient need and set supply targets**

   In the mid-1950s, there were 337.0 state hospital beds per 100,000 population. This ratio has fallen continuously to reach the woefully inadequate level of 11.7 beds per 100,000 people found in this survey. Health policy experts converge around a minimum requirement of 40 to 60 inpatient beds per 100,000 people to meet demand. However, empirical research to relate any bed target to desired outcomes—much less to differentiate targets for the many categories of psychiatric need and facilities that meet them—has not been conducted. The data and technologies exist to develop these targets. In recognition of the national scope and consequences of the bed shortage and the need to discover a safe minimum number of psychiatric beds, the federal government should undertake an assessment of bed need and advance the use of tested tools to develop realistic hospital bed targets by type, facility and setting.

2. **Identify and reform public policies that incentivize bed shortages**

   Psychiatric bed access is exceptionally sensitive to economic incentives that, for half a century, have overwhelmingly been directed at reducing the number of mental health beds in America.[9] Averting the extinction of the nation's last-resort state hospital beds, slowing the elimination of other psychiatric beds, improving access to beds that already exist and motivating the creation of enough new beds to meet demand requires reversing those incentives. A new Medicaid reimbursement rule finalized in April 2016 partially repeals the discriminatory exclusion of institutions for mental diseases ("IMD Exclusion") and is an important step in that direction. But the rule applies only to certain Medicaid managed care enrollees and addresses only one of the federal policies that contribute to bed shortages. Others include Medicare reimbursement rates that are lower for psychiatric treatment than for most other medical and surgical conditions and hospital payment formulas weighted toward private hospitals. For the benefit of patients, their communities and taxpayers, Congress should direct and fund appropriate agencies to undertake a comprehensive review to identify all federal policies that create financial incentives to close psychiatric beds, assess their economic and other impacts and make evidence-driven reforms based on the findings.

3. **Improve data collection associated with bed shortages and build public policy on the evidence**

   Without outcome data, states blindly adopt and perpetuate costly practices that may contribute to bed shortages, possibly without any offsetting public or individual benefits. According to the OECD, "The lack of data on costs, quality and outcomes inhibits a complete assessment of mental health system performance. The result is poor policy and an inability to direct scarce resources to areas of need."[10] To this end, the National Institute of Mental Health (NIMH) should fund outcome research to study the impact of mental health policies on people with serious mental illness. States should identify and assess how their state policies increase or decrease access to treatment for serious mental illness, including beds, and the effectiveness of them. The public health departments of universities should incentivize doctoral and other research projects that contribute to the body of knowledge and the public good about psychiatric issues, including bed shortages.

THE DOMINO EFFECT: DYING FOR WANT OF A BED

Jamycheal Mitchell died of a heart attack after starving himself in a Virginia jail cell for three months while waiting for a state hospital bed. He was 24.

Mitchell was arrested in April 2015 for stealing $5.05 worth of snacks from a 7-Eleven. In his delusional state, he believed it was a relative's store. Mitchell stopped taking his medication for schizophrenia. After his arrest, he was evaluated, found incompetent to stand trial and court ordered into a Virginia state hospital for restoration of his competency. Because no bed was available, he remained in jail, waiting, until he died.

Inconceivably, even starving to death in a cell has ceased to be novel.

- *Keaton Farris, diagnosed with bipolar disorder and arrested for attempting to illegally cash a check, died of malnutrition and dehydration in a Washington state jail cell in April 2015.*[11]
- *Raleigh Priester, a U.S. Army veteran with schizophrenia and a long history of arrests and hospitalizations, died in a Broward County, Florida, jail after losing half his body weight over a five-month period.*[12]
- *In North Carolina, Michael Kerr died of dehydration in March of 2014 while in solitary confinement; the Associated Press reported he was not receiving treatment for his schizophrenia. North Carolina reached a settlement with his estate a year later.*[13]

The finger-pointing to fix blame for Mitchell's death in Virginia has been intense and isn't finished. While it rages, other inmates continue waiting. A month after Mitchell's death, Virginia state officials told the Washington Post *that 89 inmates, like Mitchell, had been found officially in need of a bed that wasn't available. Their average wait: 73 days.*[14]

4. **Increase the use of diversion strategies that reduce hospitalization rates**
   Tools and strategies exist to intercept and treat people with serious mental illness before they need the last resort of a state hospital bed. None is implemented universally; some are barely used at all. The following three evidence-based practices are associated with reduced emergency room visits and psychiatric hospitalizations. Widely implementing even these three would help reduce the impact of bed shortages.

   a. Assisted outpatient treatment (AOT): A treatment option that utilizes a court order to require adherence to treatment for mentally ill individuals with a history of treatment nonadherence and rehospitalization or reincarceration, among other criteria

   b. Assertive community treatment (ACT, which may be included in AOT plans or independent): A multidisciplinary team approach to serving mentally ill patients where they live

   c. Sequential Intercept Model: A conceptual framework for preventing individuals with mental illness from entering or penetrating deeper into the criminal justice system. Among the intercepts are practices such as the use of mobile crisis teams and de-escalation training for law enforcement officers.

And, of course, states must stop closing the beds we still have before they are no longer "going" but entirely "gone."

Some states have built high- or medium-security forensic hospitals on prison grounds for mentally ill inmates. The numbers of such beds are not reported in this survey, nor do we recognize the strategy as a viable practice, even if it arguably could reduce demand for state hospital beds. Beds behind bars effectively bring the criminalization of mental illness full circle—back to

THE DOMINO EFFECT: FEWER BEDS, LONGER WAITS IN THE ER

In 2009, Sacramento County, California, eliminated 50 of the 100 beds in the county's inpatient facility and closed its outpatient crisis stabilization unit. The effect of these actions on the university hospital emergency room next door illustrates how reducing access to psychiatric treatment in one segment of the mental health system increases the demand and strain in others.*

In this case, access to both inpatient and outpatient resources was eliminated. Reduced treatment options in the county of 1.4 million people quickly produced more psychiatric emergencies involving sicker people who increasingly overwhelmed the local emergency room, where they waited longer for treatment and displaced more nonpsychiatric patients.[15]

To assess the impact of the bed and service reductions, Arica C. Nesper and colleagues compared emergency room use at the UC Davis Medical Center in the 8 months before the beds and outpatient services were closed and the 8 months following. They found the following:

- *The number of ER visits requiring psychiatric consultation tripled.*
- *The average time psychiatric patients spent waiting to be seen by a psychiatric clinician in the ER increased from an average of 14 hours to nearly 22 hours.*
- *The average number of psychiatric patients held in the ER longer than 24 hours skyrocketed from 28 patients in the 8 months before the county closures to 322 in the 8 months afterward.*
- *The number of psychiatric consultations when the most serious symptoms of psychiatric crisis—assaultive or suicidal behavior—were the chief complaint ballooned from 58 to 283. The number of patients presenting with hallucinations rocketed from 18 to 79.*
- *A smaller percentage of the patients—who now included more severely ill patients—were ultimately transferred to hospital beds; more were discharged home instead.*
- *The number of hours that psychiatric patients occupied bed space in the ER per stay rose from approximately 18 hours per patient to 97 hours, substantially affecting the flow of other patients through the ER. Care for as many as 13 to 20 nonpsychiatric patients may have been delayed or "displaced" as a result.*

"Ultimately, more than a 5-fold increase occurred in daily ED (emergency department) bed hours occupied by a patient receiving psychiatry consultation after this decrease in county mental health services," the authors concluded.[16] *In a functional mental health system, public hospitals—state and county facilities like Sacramento's—represent one point on a care continuum that also includes outpatient treatment for patients on the entire spectrum of illness: community services to support stability and prevent deterioration, hospital and residential beds to respond to acute illness, and medium- and long-term care to support recovery, among others.*

Sacramento's experience illustrates that if there is one thing more dysfunctional than reducing access to hospital treatment, it's reducing access to hospital and *community treatment at the same time.*

Arica C. Nesper et al.
"Effect of Decreasing County Mental Health Services on the Emergency Department"
Annals of Emergency Medicine (2015)

* In states as large as California, some counties operate public hospitals.

colonial times and the early 19th century, when the mentally ill were routinely jailed or kept in "poor houses." Beds behind bars are not counted in this survey because we regard this practice as an inhumane and unacceptable public policy for the treatment of disease. We would not call it just to incarcerate a man who crashed his car because he had a heart attack behind the wheel. Why would a just society incarcerate those with serious mental illness for the equivalent?

BACKGROUND

State mental hospitals—once called asylums because they were associated with protection—are remnants of a 19th-century reform movement to restore sanity with treatment and to provide shelter and humane care for individuals with serious mental illness. Since the mid-20th century, when state hospitals provided nearly 560,000 beds, a host of medical, social, political and economic factors have converged to shrink the bed population for adults in the U.S. by nearly 97%.

At the outset of the hospital construction era in 1850, there were 14 beds per 100,000 people in America. By 2010, public bed populations in state hospitals had sunk back to 14.1 beds per 100,000 people from their peak of 337.0 per 100,000 people in 1955.[17] By the first quarter of 2016, our survey of the states found the ratio had dropped an additional 17% to its lowest level on record: 11.7 beds per 100,000 people.

To put this in context, the Organization for Economic Cooperation and Development (OECD) ranks its 34 member nations—which include the United States—by their total psychiatric bed numbers. The OECD reported an average of 68 psychiatric beds per 100,000 people among its member states in 2011 or the nearest year available. Including state, county, general, community and private psychiatric beds, the United States ranked 29th, with a total combined public and private bed population of 25 beds per 100,000 people. Only New Zealand, Chile, Italy, Turkey and Mexico provided fewer beds.[18] Given the pace at which the U.S. continues closing both public and private beds, the ranking today is likely even lower.

State hospitals play a crucial role that is duplicated rarely or unevenly elsewhere in the U.S. health care system. They treat people in circumstances that are not, or cannot be, adequately addressed in a community setting. This population includes

- uninsured and indigent patients,
- pretrial defendants being "restored" to competency so they can stand trial,
- criminal defendants found "unrestorable" who remain hospitalized under civil commitment criteria,
- individuals who are violent or dangerous to self or others,
- jail inmates in need of psychiatric evaluation or treatment to restore their competency to stand trial,
- defendants being evaluated for criminal responsibility in conjunction with an "insanity" defense or for treatment in lieu of incarceration, and
- convicted prisoners in need of intensive psychiatric care.

The idea behind downsizing the state hospitals that treat these populations was fundamentally sound: Most psychiatric patients could live safely and be treated successfully in community facilities, provided such facilities existed. And many have. The rub came when and where the substitute facilities did not exist—when they were not widely constructed or were constructed and almost exclusively served more functional clients than state hospitals once did.[19] The further reality that approximately 25% of individuals with psychotic disorders do not respond to treatment and hence are unable to rejoin the community without substantial support was left completely unaddressed. In its report on 2010 bed populations, the Treatment Advocacy Center called the resulting treatment gap for individuals with the most serious psychiatric diseases "disastrous."[20]

Since then, the situation has become beyond disastrous.

- Approximately 6,000 state hospital beds were eliminated from 2010 to early 2016 (see Table 1). At the same time, the U.S. population grew by approximately 14 million people.
- Sixteen state hospitals in nine states closed or merged from 2010 to 2016. By July 2015, the number of state hospitals in the United States numbered 195, down from 254 in 1997, a 24% reduction in less than 20 years.[21]
- County, general and private hospital beds continued to decline in tandem with state hospitals. The Subcommittee on Acute Care of the New Freedom Commission appointed by President George W. Bush reported in 2004 that the number of inpatient beds per capita fell 43% from 1990 through 2000 and 32% in nonfederal general hospitals.[22] The shrinkage continues.
- Fewer beds resulted in people in crisis waiting longer for the ones that remained. Nearly 90% of surveyed emergency physicians reported in 2015 that mentally ill patients were being "held" in their ERs for lack of hospital beds to admit them to, a practice known as "boarding"[23] (see "The Domino Effect: Fewer Hospital Beds, Longer Waits in the ER for Everyone").
- 70% of ER physician survey respondents in 2015 said their ERs boarded patients in psychiatric crisis for more than 24 hours; 10% reported boarding them for a week or more.[24]

Table 1. *State Hospital Beds Remaining in 2016*

STATE	2016 TOTAL STATE HOSPITAL BEDS	2010 TOTAL STATE HOSPITAL BEDS	NUMBER OF BEDS LOST OR GAINED	2016 BEDS PER 100,000 POPULATION	RELATION TO TARGET BEDS PER CAPITA
Alabama	383	1,119	-736	7.9	15.8%
Alaska	80	52	28	10.8	21.7%
Arizona	302	260	42	4.4	8.8%
Arkansas	222	203	19	7.5	14.9%
California	5,905	5,283	622	15.1	30.2%
Colorado	543	520	23	10.0	19.9%
Connecticut	615	741	-126	17.1	34.3%
Delaware	122	209	-87	12.9	25.8%
District of Columbia	282	*	*	42.0	84.0%
Florida	2,648	3,321	-673	13.1	26.1%
Georgia	954	1,187	-233	9.3	18.7%
Hawaii	202	182	20	14.1	28.2%
Idaho	174	155	19	10.5	21.0%
Illinois	1,341	1,429	-88	9.3	18.7%
Indiana	818	908	-90	12.4	24.7%
Iowa	64	149	-85	2.0	4.1%
Kansas	451	705	-254	15.5	31.0%
Kentucky	499	446	53	11.3	22.6%
Louisiana	616	903	-287	13.2	26.4%
Maine	144	137	7	10.8	21.7%
Maryland	950	1,058	-108	15.8	31.6%

* District of Columbia bed numbers not collected in 2010

Table 1. ***State Hospital Beds Remaining in 2016, continued***

STATE	2016 TOTAL STATE HOSPITAL BEDS	2010 TOTAL STATE HOSPITAL BEDS	NUMBER OF BEDS LOST OR GAINED	2016 BEDS PER 100,000 POPULATION	RELATION TO TARGET BEDS PER CAPITA
Massachusetts	608	696	-88	8.9	17.9%
Michigan	725	530	195	7.3	14.6%
Minnesota	194	206	-12	3.5	7.0%
Mississippi	486	1,156	-670	16.2	32.5%
Missouri	874	1,332	-458	14.4	28.8%
Montana	174	194	-20	16.8	33.7%
Nebraska	289	337	-48	15.2	30.5%
Nevada	296	302	-6	10.2	20.5%
New Hampshire	158	189	-31	11.9	23.7%
New Jersey	1,543	1,922	-379	17.2	34.4%
New Mexico	229	171	58	11.0	22.0%
New York	3,217	4,958	-1,741	16.3	32.5%
North Carolina	892	761	131	8.9	17.8%
North Dakota	140	150	-10	18.5	37.0%
Ohio	1,121	1,058	63	9.7	19.3%
Oklahoma	431	401	30	11.0	22.0%
Oregon	653	700	-47	16.2	32.4%
Pennsylvania	1,334	1,850	-516	10.4	20.8%
Rhode Island	130	108	22	12.3	24.6%
South Carolina	373	426	-53	7.5	15.0%
South Dakota	128	238	-110	14.9	29.8%
Tennessee	562	616	-54	8.5	17.0%
Texas	2,236	2,129	107	8.1	16.3%
Utah	252	310	-58	8.4	16.8%
Vermont	25	52	-27	4.0	8.0%
Virginia	1,526	1,407	119	18.2	36.4%
Washington	729	1,220	-491	10.2	20.3%
West Virgina	260	259	1	14.1	28.2%
Wisconsin	458	558	-100	7.9	15.9%
Wyoming	201	115	86	34.3	68.6%
TOTALS	**37,559**	**43,318**	**-5,759**	**11.7**	**23.4%**

Behind bars, a parallel treatment gap grew, with equally devastating impact.

- In 44 states and the District of Columbia, a prison or jail holds more individuals with serious mental illness than the largest remaining state psychiatric hospital.[25]
- Suicide is the leading cause of death in jails, yet suicide and suicide attempts represent a small share of the acts of self-harm inmates inflict. Self-mutilation is commonplace, especially in solitary confinement, where mentally ill prisoners make up most of the population.[26]
- Jail and prison personnel untrained to be mental health workers are consigned to supervising psychotic and otherwise disordered inmates, leading to dangerous conditions and injuries in both groups.[27]
- Media reports of resulting tragedies—starvation deaths like Jamycheal Mitchell's, the alleged beating death of mentally ill inmate Michael Tyree by jail guards in California, the suicide of a man who swallowed razor blades in his cell—are uncommon enough to remain shocking but are no longer extraordinary.
- 75% of 39 state hospitals responding to a 2014 industry survey said demand for forensic services in their states had increased "a lot" or "moderately" in recent years. Only four states reported no change in forensic service demands; none reported that demand had decreased.[28]
- 78% of 40 state hospital officials responding to a survey in 2015 reported maintaining wait lists for forensic beds. The waits were "in the 30-day range" in most states, but three states reported forensic bed waits of six months to one year.[29]
- A growing number of states are being sued—some repeatedly—over forensic bed waits or other conditions involving mentally ill prisoners, and more lawsuits are threatened.

Between the two populations—mentally ill individuals inside and outside the criminal justice system—a bed shell game with life-and-death implications has ensued. Without enough beds to go around, states prioritize. Where bed access for patients who have committed crimes is given priority, bed waits behind bars tend to be shorter, and fewer civil patients are served. In states where bed access for noncriminal patients is preserved, forensic wait lists swell, and more civil patients are served. Although the tactic doesn't typically eliminate bed waits completely for either population, one population benefits somewhat, at the expense of the other (see "The Domino Effect: Treating More Forensic Patients Sooner by Treating Fewer Civil Patients").

The deplorable state of America's mental health care is hardly a function of state hospital bed shortages alone. Private and community bed shortages and a dearth of long-term residential care options have resulted from discriminatory Medicaid and Medicare reimbursement policies. State mental health budget cuts, which reached draconian proportions following the financial crisis, have reduced access to mental health treatment at every stop on the way to state hospitals. Mental health professionals are in dire shortage. Of the nation's 3,100 counties, 55% have no practicing psychiatrists, psychologists or social workers.[30] Promising early-intervention treatment models that could improve long-term outcomes of the most serious mental illnesses rely on community-based mental health services that can't be provided where providers don't exist. At the same time, an estimated 14,000 of America's 35,000 practicing psychiatrists are over the age of 55 and heading toward retirement, without new psychiatrists being graduated at anywhere near a replacement rate;[31,32] in states like South Dakota, state hospital bed waits are more a function of psychiatrist shortages than bed shortages.[33] Beyond the public system, a Mayo Clinic–affiliated psychiatric unit in Wisconsin closed in March 2016 because of psychiatric personnel shortages.[34]

Meanwhile, essential residential and supported housing for patients released from hospitals are at least as scarce as hospital beds. In November 2015, Virginia's mental health department

reported that 7% of the bed capacity at one of the commonwealth's state hospitals was occupied by "20 individuals who have been clinically ready for discharge for more than 30 days, but have extraordinary barriers that prevent them from being reintegrated in their community in a timely manner." At the same time, 24 individuals were reported to be in jail waiting for one of those beds for evaluation or treatment to restore competency.[35]

Comprehensive mental health care reform and practices that address treatment gaps and deficiencies along the entire continuum of care are desperately needed. Until they are in place and operating, shutting down the last resort for treatment of gravely ill people who endanger themselves and their communities is premature, inefficient, expensive, inhumane and deadly.

THE DOMINO EFFECT:
TREATING MORE FORENSIC PATIENTS SOONER BY TREATING FEWER CIVIL PATIENTS

Colorado was sued in 2011 over its alleged failure to provide timely competency evaluations and treatment for pretrial inmates. In 2012, the state and Disability Law Colorado, which had filed the suit on behalf of affected inmates, reached a compromise meant to ensure that criminal defenders spent less time in jail waiting for a bed.

Under the settlement, the state Department of Health Services agreed to complete competency evaluations of pretrial inmates in the jails within 30 days of a court order or to admit them to the state hospital for evaluation within 28 days. Offenders found incompetent to stand trial were to be admitted to the state hospital or an in-jail program within 28 days of the finding. Monthly reports to Disability Law detailing when evaluation or treatment began for each inmate were required.

The settlement agreement had the desired effect of reducing how long forensic patients waited in jail for competency evaluations in one of the state's two state hospitals. "The average length of stay for defendants admitted for competency evaluations was greatly decreased, to 35 days at CMHIP (Colorado Mental Health Institute at Pueblo) and 38 days at the Colorado Mental Health Institute at Fort Logan (CMHIFL), as compared to 102 days prior to the lawsuit," according to an April 2015 analysis of existing services and future needs reported to the state's Department of Human Services.[36]

However, improved conditions for forensic patients came at the expense of civil patients. "A side effect of the settlement agreement has been fewer beds available for civil commitments," the report said. "The percentage of civil referrals being denied admission has increased substantially for both institutes, from 21 percent to 38 percent at CMHIP, largely due to referrals for competency evaluations."[37]

Intensifying the impact on civil patients was the length of stay for pretrial patients who require treatment to restore their competency to stand trial. "With nearly one-quarter of these individuals staying more than one year, CMHIP is forced to use a larger and larger portion of its civil beds to serve this population. The combination of increased admissions and longer lengths of stay is the driving force behind a projected shortage of beds over the next decade."[38]

The Western Interstate Commission for Higher Education, which conducted the assessment, concluded Colorado would need to increase its state hospital bed population by 90%—from 545 to 1,033 beds—by 2025 to "keep pace with increasing forensic admissions and to maintain the current civil bed rate,"[39] which ranks 34th in the Treatment Advocacy Center's current state survey.

Things haven't improved since then.

In October 2015, Disability Law Colorado filed a motion accusing the Department of Human Services of submitting "misleading and false data" in four of its required monthly reports and then covering up the falsifications.[40] In early 2016, the legislature began deliberating a bill giving sheriffs specific authority to use jails for up to 48 hours—longer over weekends and holidays—to contain citizens who had not committed a crime but were in psychiatric crisis if no hospital bed was available.

METHODOLOGY

State hospital bed numbers reported in *Going, Going, Gone* were collected in the first quarter of 2016 for patients 18 years or older. Data include voluntary and involuntary beds for patients who enter treatment either through the civil (non-criminal) or the forensic (criminal justice) systems.

Survey data for both bed classifications were collected in the 50 states and District of Columbia from three principal sources:

- Official state publications, including state websites, state reports and departmental reports to governors and legislative committees
- Email or telephone interviews with personnel in state mental health departments, state hospitals, public information offices and other state agencies with access to bed statistics
- Court filings associated with lawsuits against states for their treatment of mentally ill inmates

In states where beds exist but nobody is in them because they are not staffed (e.g., Kentucky, Minnesota, New York, Nebraska, Texas), the number of beds in operation is reported, not the beds that are approved but empty. Child and adolescent beds, which account for about 1% of state hospital budgets,[41] were excluded. Residential and geriatric state hospital beds that were characterized as primarily providing residential care to individuals with Alzheimer's, senile dementia and other age-related conditions—again, a small percentage of total beds—were excluded, as were beds for convicted sexual offenders, who are housed in state hospitals in some states even though not mentally ill.

States were surveyed for both their forensic hospital bed allocations and patient censuses. "Allocations" refers to the number of beds that states have been officially designated, budgeted and/or reserved for patients who are involved with the criminal justice system. "Census" refers to actual occupancy. In states where civil beds are being repurposed to meet forensic demand (e.g., Indiana, Massachusetts, Ohio), forensic bed occupancy typically exceeds forensic allocations. References to the ratio of forensic to other beds in all cases refer to occupancy, not allocation.

More detailed forensic bed wait information was solicited from a sample of 25 states in interviews conducted during March and April 2016. Sample states were asked for the following data:

- Number of inmates wait-listed for a state hospital bed
- Average (mean) time from being wait-listed for a bed to being admitted to one
- Average length of stay for forensic patients found not guilty by reason of insanity
- Forensic bed occupancy rates for 2015

When necessary and available, media reports were used to validate numbers from official sources. In each of the sample states, applicable statutes and regulations were reviewed to identify legal parameters that might govern or influence the classification, number and/or use of forensic beds.

Since the publication of the Treatment Advocacy Center's first survey of hospital beds in 2008, a per capita level of 50 psychiatric beds per 100,000 population has been widely accepted as a credible measure of bed supply adequacy. No better evidence-based benchmark having emerged since then, the 50/100,000 number continues to be used for comparative purposes in this survey.

One strength of this study is that it contains the most complete and current state hospital bed statistics available, including the numbers and ratios of forensic bed allocations and occupancy to total bed populations in each state. The 25-state sample goes beyond bed counts alone to examine bed trends in the context of applicable state laws and regulations affecting them, which illuminates how public policies can reduce or increase bed demand.

Limitations of the study include inconsistent data sets or timing resulting from variations in the laws that regulate state hospital beds and/or the techniques states use to collect data and report their statistics. For example, some states maintain real-time bed registries; others report bed counts weekly, monthly or annually. Forensic bed waits also are tracked and reported differently among the states; some report daily totals, while others average waits by the week or month. The average time inmates spend on a forensic wait list was subject to whether states prioritized patients and on what basis, such as clinical need or date of court order.

Hospital bed numbers are subject to circumstances that can change daily, even hourly. This affects the precision of numbers on any given date but does not materially affect the trends they reveal.

STATISTICS MAY NOT LIE BUT THAT DOESN'T MAKE THEM TOTALLY RELIABLE

States are not always reliable sources of their own data, undermining the precision of state bed surveys, regardless of who conducts them. The obstacles we encountered in surveying the states for Going, Going, Gone *typically fell into one of three categories.*

- ***State officials are not knowledgeable.***

  A 2014 National Association of State Mental Health Program Directors (NASMHPD) report on forensic mental health services noted that 41 or 42 respondents said their states recognize the insanity defense, "including respondents from 3 of the states in which the defense formally has been abolished."[42] Our survey elicited similarly conflicting answers when identical questions were posed to different officials within the same state. We defaulted to the answer that was corroborated elsewhere (e.g., in a report or on the state website) or came from the official of the highest rank who had direct knowledge of the subject.

- ***States report different numbers to different sources.***

  The state of Pennsylvania reported a total population of 2,495 state hospital beds to the NASMHPD Research Institute in late 2015, a population of 1,531 on its official website in early 2016 and, at the same time, a population of 1,334 to the Treatment Advocacy Center. Other states reported similarly inconsistent statistics. We defaulted to the data state officials personally conveyed to us.

- ***States choose to withhold or obfuscate the truth.***

  Our inquiries were not always answered with complete information. In New Hampshire, a state official hung up on the interviewer. In Illinois, state officials did not pick up the telephone or return calls or emails left during a two-month period; ultimately, a University of Chicago law professor was recruited to find a responsive state official for us. In Colorado, Disability Law Colorado filed a motion in federal court accusing the state of falsifying its court-ordered monthly reports on forensic bed waits.

FINDINGS

In 2015, there were an estimated 8.1 million individuals with schizophrenia or severe bipolar disorder in the United States, about half of them untreated at any given time.[43] Because of the severity of their symptoms when untreated and their heightened risk of being arrested and/or impoverished as a result, these are the citizens most likely to be admitted to a last-resort bed in a state hospital, as either civil or forensic patients.

Our 2016 survey of state psychiatric bed populations found the following:

- 37,559 staffed beds remained in state hospitals. This represented a 17% reduction in the bed population since 2010, when 43,318 beds remained.[44]
- 11.7 beds remained per 100,000 population. This compares with an average of about 68 beds per 100,000 people in the Organization for Economic Cooperation and Development (OECD) and marked the lowest per capita state bed availability since the nation began decriminalizing mental illness in the 1850s.[45]
- Of the 11.7 beds per 100,000 population, roughly half were available to civil psychiatric patients—people who had not committed crimes.
- "Boarding" psychiatric patients in emergency rooms while waiting for beds somewhere in the psychiatric inpatient system was virtually universal.[46]
- Of the 11.7 beds per 100,000 population, the other half were occupied by forensic patients admitted to the hospital via the criminal justice system. In two states, Hawaii and Missouri, all of them were.
- Because far more inmates are in need of or ordered by courts into hospitals than there are beds for them, they are placed on wait lists in most states, sometimes for months.[47]
- Those states without long forensic bed waits often have avoided them by diverting civil beds to forensic uses, leading to longer waits in the ERs where the civil patients accumulate.
- A growing number of states are resorting to hospital beds behind bars—psychiatric treatment facilities operated as part of the state's penal system.

Survey of the States

Our 2012 survey report, *No Room in the Inn* found that, in 2010, 11 states continued to provide at least 20 psychiatric beds per 100,000 population.[48] About 51 million people lived in those states. By the first quarter of 2016, only 2 states continued to provide at least 20 beds for each 100,000 people: Wyoming and the District of Columbia. They were home to roughly 1.2 million of America's 321 million residents (see Table 2).

In 17 states, fewer than 10 beds remained per 100,000 people by early 2016: Alabama, Arizona, Arkansas, Georgia, Illinois, Iowa, Massachusetts, Michigan, Minnesota, North Carolina, Ohio, South Carolina, Tennessee, Texas, Utah, Vermont and Wisconsin.

In 4 states, fewer than 5 beds remained per 100,000 population: Arizona, Iowa, Minnesota and Vermont. Arizona, Iowa and Minnesota were also at the bottom of the rankings in 2010; Vermont lost its state hospital to Hurricane Irene in 2012 and only recently restored some of those beds.

Table 2. *State Hospital Bed Populations by State and Rank*

STATE	2010 TOTAL STATE HOSPITAL BEDS	2010 BEDS PER 100,000 POPULATION	RANK AMONG THE STATES	2016 TOTAL STATE HOSPITAL BEDS	2016 BEDS PER 100,000 POPULATION	RANK AMONG THE STATES
Iowa	149	4.9	48	64	2.0	51
Minnesota	206	3.9	50	194	3.5	50
Vermont	52	8.3	42–43	25	4.0	49
Arizona	260	4.1	49	302	4.4	48
Michigan	530	5.4	47	725	7.3	47
Arkansas	203	7.0	46	222	7.5	45–46
South Carolina	426	9.2	39	373	7.5	45–46
Alabama	1,119	23.4	5	383	7.9	43–44
Wisconsin	558	9.8	37	458	7.9	43–44
Texas	2,129	8.5	41	2,236	8.1	42
Utah	310	11.2	27–28	252	8.4	41
Tennessee	616	9.7	38	562	8.5	40
North Carolina	761	8.0	44	892	8.9	38–39
Massachusetts	696	10.6	31	608	8.9	38–39
Illinois	1,429	11.1	29	1,341	9.3	36–37
Georgia	1,187	12.3	26	954	9.3	36–37
Ohio	1,058	9.2	39–40	1,121	9.7	35
Colorado	520	10.3	35	543	10.0	34
Washington	1,220	18.1	17	729	10.2	32–33
Nevada	302	11.2	27–28	296	10.2	32–33
Pennsylvania	1,850	14.6	20	1,334	10.4	31
Idaho	155	9.9	36	174	10.5	30
Maine	137	10.3	32–35	144	10.8	28–29
Alaska	52	7.3	45	80	10.8	28–29
New Mexico	171	8.3	42–43	229	11.0	26–27
Oklahoma	401	10.7	30	431	11.0	26–27
Kentucky	446	10.3	32–35	499	11.3	25
New Hampshire	189	14.4	21	158	11.9	24
Rhode Island	108	10.3	32–35	130	12.3	23
Indiana	908	14.0	24	818	12.4	22
Delaware	209	23.3	6	122	12.9	21
Florida	3,321	17.7	18	2,648	13.1	20
Louisiana	903	19.9	12	616	13.2	19
West Virgina	259	14.0	23–24	260	14.1	17–18
Hawaii	182	13.4	25	202	14.1	17–18
Missouri	1,332	22.2	8	874	14.4	16
South Dakota	238	29.2	2	128	14.9	15
California	5,283	14.2	22	5,905	15.1	14

Table 2. *State Hospital Bed Populations by State and Rank, continued*

STATE	2010 TOTAL STATE HOSPITAL BEDS	2010 BEDS PER 100,000 POPULATION	RANK AMONG THE STATES	2016 TOTAL STATE HOSPITAL BEDS	2016 BEDS PER 100,000 POPULATION	RANK AMONG THE STATES
Nebraska	337	18.5	14	289	15.2	13
Kansas	705	24.7	4	451	15.5	12
Maryland	1,058	18.3	15–16	950	15.8	11
Oregon	700	18.3	15–16	653	16.2	9–10
Mississippi	1,156	39.0	1	486	16.2	9–10
New York	4,958	25.6	3	3,217	16.3	8
Montana	194	19.6	13	174	16.8	7
Connecticut	741	20.7	10	615	17.1	6
New Jersey	1,922	21.9	9	1,543	17.2	5
Virginia	1,407	17.6	19	1,526	18.2	4
North Dakota	150	22.3	7	140	18.5	3
Wyoming	115	20.4	11	201	34.3	2
District of Columbia	*	*	*	282	42.0	1
TOTALS	**43,318**	**14.1**		**37,559**	**11.7**	

* District of Columbia bed numbers not collected in 2010

In 17 states, sufficient additional beds were added from 2010 to 2016 for the per capita rate to rise. In no state, however, did the increase boost a state's ratio to 20 beds per 100,000 population from the teens or below.* In most states, the increase simply made an abysmal ratio marginally less abysmal. For example, Arizona's beds per capita, which ranked 49th among the states in 2010 at 4.1 beds per 100,000 people, rose to 4.4. West Virginia rose from 14.0 beds per 100,000 to 14.1. Given how fluid jail census numbers are, "growth" this miniscule is as likely to be a statistical fluke as a sign of any real improvement.

Merely counting beds and reporting their ratio to state populations, however, does not fully reveal the trends and consequences of the bed shortage.

As the ER boarding data show, when beds are not available, people in psychiatric crisis back up in hospital emergency rooms or, worse, are discharged with no care at all, a practice known as "streeting."[49] When beds are not available for mentally ill inmates, their numbers grow in jail and prison cells, including solitary confinement.

Before deinstitutionalization, jails and prisons held relatively few mentally ill inmates. This made for few forensic patients for state hospitals to treat. By 2014, a prison or jail held more individuals with serious mental illness than the largest remaining state psychiatric hospital in 44 states and the District of Columbia. At least 20% of jail and prison inmates were estimated to suffer from a serious mental illness, though sheriffs around the country occasionally report populations running as high as 50% in their jails.[50]

* Wyoming, which reached 34.3 beds in 2016, already ranked 11th among the states in 2010, with 20.4 beds per 100,000 people. District of Columbia was not ranked in 2010.

Table 3. *Forensic Bed Populations by State*

STATE	TOTAL STATE HOSPITAL BEDS	DESIGNATED FORENSIC BEDS	% OF ALL BEDS DESIGNATED FORENSIC	CENSUS OF FORENSIC PATIENTS	% OF ALL BEDS OCCUPIED FORENSIC
Alabama	383	115	30.0	115	30.0
Alaska	80	10	12.5	10	12.5
Arizona	302	143	47.4	143	47.4
Arkansas	222	126	56.8	156	70.3
California	5,905	4,412	74.7	4,412	74.7
Colorado	543	184	33.9	184	33.9
Connecticut	615	232	37.7	232	37.7
Delaware	122	42	34.4	42	34.4
District of Columbia	282	0	0.0	158	56.0
Florida	2,648	1,124	42.4	1,559	58.9
Georgia	954	641	67.2	641	67.2
Hawaii	202	198	98.0	198	98.0
Idaho	174	55	31.6	55	31.6
Illinois	1,341	802	59.8	896	66.8
Indiana	818	88	10.8	267	32.6
Iowa	64	0	0.0	38	59.4
Kansas	451	200	44.3	200	44.3
Kentucky	499	0	0.0	0	0.0
Louisiana	616	70	11.4	70	11.4
Maine	144	44	30.6	47	32.6
Maryland	950	853	89.8	853	89.8
Massachusetts	608	0	0.0	70	11.5
Michigan	725	210	29.0	384	53.0
Minnesota	194	0	0.0	0	0.0
Mississippi	486	35	7.2	35	7.2
Missouri	874	874	100.0	874	100.0
Montana	174	59	33.9	59	33.9
Nebraska	289	67	23.2	67	23.2
Nevada	296	76	25.7	76	25.7
New Hampshire	158	0	0.0	0	0.0
New Jersey	1,543	200	13.0	471	30.5
New Mexico	229	44	19.2	44	19.2
New York	3,217	720	22.4	720	22.4
North Carolina	892	84	9.4	236	26.5
North Dakota	140	65	46.4	65	46.4
Ohio	1,121	0	0.0	714	63.7
Oklahoma	431	200	46.4	200	46.4
Oregon	653	416	63.7	439	67.2
Pennsylvania	1,334	236	17.7	236	17.7
Rhode Island	130	28	21.5	28	21.5
South Carolina	373	215	57.6	215	57.6

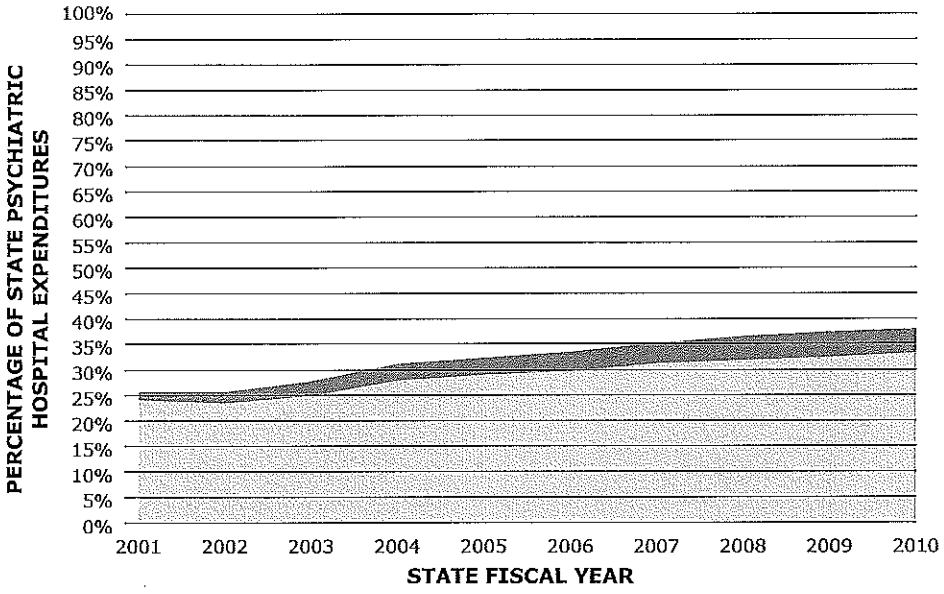
Table 3. *Forensic Bed Populations by State, continued*

STATE	TOTAL STATE HOSPITAL BEDS	DESIGNATED FORENSIC BEDS	% OF ALL BEDS DESIGNATED FORENSIC	CENSUS OF FORENSIC PATIENTS	% OF ALL BEDS OCCUPIED FORENSIC
South Dakota	128	0	0.0	0	0.0
Tennessee	562	0	0.0	100	17.8
Texas	2,236	1,047	46.8	1,216	54.4
Utah	252	100	39.7	100	39.7
Vermont	25	0	0.0	10	40.0
Virginia	1,526	356	23.3	356	23.3
Washington	729	138	18.9	138	18.9
West Virgina	260	0	0.0	95	36.5
Wisconsin	458	349	76.2	349	76.2
Wyoming	201	28	13.9	28	13.9
TOTALS	**37,559**	**14,886**		**17,601**	

When inmates require psychiatric evaluation or treatment, the state hospital is the most common—in many circumstances, the only—facility where they can be admitted. Our survey of the states found the following with regard to forensic patients (see Table 3):

- In 16 states, more than 50% of the remaining state hospital beds were occupied by forensic patients: Arkansas, California, District of Columbia, Florida, Georgia, Hawaii, Illinois, Iowa, Maryland, Michigan, Missouri, Ohio, Oregon, South Carolina, Texas and Wisconsin.
- In an additional 18 states, forensic patients occupied 25% to 49% of the state hospital beds: Alabama, Arizona, Colorado, Connecticut, Delaware, Idaho, Indiana, Kansas, Maine, Montana, Nevada, New Jersey, North Carolina, North Dakota, Oklahoma, Utah, Vermont and West Virginia.
- In two states—Hawaii and Missouri—officials reported the state hospitals were essentially 100% dedicated to forensic use.
- In only one state—Mississippi—did forensic patients occupy fewer than 10% of the state hospital beds.
- Of the roughly 6 forensic beds per 100,000 population, 50.5% of those in our sample of 25 states were occupied by patients found not guilty by reason of insanity, who may spend decades or their entire remaining lifetimes in the hospital. This effectively left 3 beds per 100,000 people for mentally ill inmates in need of pretrial services or other inpatient treatment.
- Three states reported no forensic beds because they provide psychiatric treatment to inmates entirely in forensic units at state prisons: Kentucky, New Hampshire and South Dakota. The move to beds behind bars does not guarantee a sufficient supply of beds for demand: In Kentucky, an average of 37 inmates waited an average of three weeks each for a bed in the first quarter of 2016.[51]
- State hospital budgets reflect the shift from civil to forensic treatment. In 1990, 10% of state psychiatric hospital expenditures were for forensic services; by 2010, the figure had risen to 40%[52] and was still going up (see Figure 1).

Figure 1. ***Forensic and Sex Offender Expenditures as a Percentage of State Psychiatric Hospital Expenditures Fiscal Years 2001 to 2010***

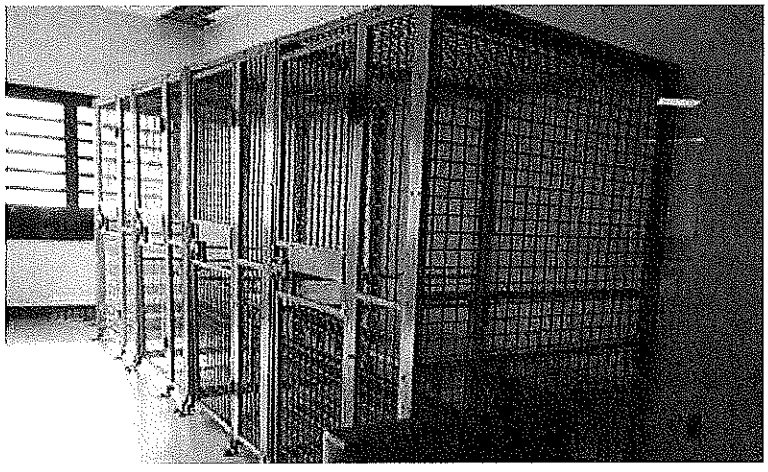


Source: National Association of State Mental Health Program Directors Research Institute. (2012). FY 2010 State Mental Health Revenues and Expenditures. Retrieved from http://media.wix.com/ugd/186708_c6beb833346b45429322cc4421d83aa1.pdf

In a bizarre display of how thoroughly mental illness is returning to its status as a criminal condition, New Hampshire authorizes civil patients who have committed no crime to be treated inside the state's Secure Psychiatric Unit—a prison. Figure 2 is a photograph of the cages where group therapy sessions are conducted for civilly committed patients.

A bill to prohibit the practice was introduced this year but referred for study, which means it passed no committee or legislative chamber and received no hearing. Meanwhile, over the state line, a Maine bill to authorize transferring selected patients from the state hospital in Augusta to a prison psychiatric unit like New Hampshire's fell short of passage by one vote in April. The candidate patients also were people who had not been charged with or convicted of crimes.

Figure 2. ***Group Therapy Booths for Civil Patients in the New Hampshire Secure Psychiatric Unit***



Source: Nancy West, New Hampshire Center for Public Interest Journalism

Families and friends of the mentally ill routinely report that police officers, mental health workers and other families advise that the most reliable way for their loved one to get treatment is to be arrested. The dwindling number of beds for patients who haven't committed crimes is one explanation (see Table 4).

- In only 13 states do at least 10 nonforensic beds remain per 100,000 people: Connecticut, District of Columbia, Kentucky, Louisiana, Mississippi, Montana, Nebraska, New Hampshire, New Jersey, New York, South Dakota, Virginia and Wyoming.
- In 22 states, only 5 to 9 civil beds are available per 100,000 people.
- In 16 states—including the 2 where no civil beds remain—fewer than 5 civil beds remain for each 100,000 people.

Table 4. *State Hospital Bed Population by Legal Status*

STATE	CIVIL BEDS PER 100,000 POPULATION	FORENSIC BEDS PER 100,000 POPULATION	TOTAL BEDS PER 100,000 POPULATION*
Alabama	5.5	2.4	7.9
Alaska	9.5	1.4	10.8
Arizona	2.3	2.1	4.4
Arkansas	2.2	5.2	7.5
California	3.8	11.3	15.1
Colorado	6.6	3.4	10.0
Connecticut	10.7	6.5	17.1
Delaware	8.5	4.4	12.9
District of Columbia	18.4	23.5	42.0
Florida	5.4	7.7	13.1
Georgia	3.1	6.3	9.3
Hawaii	0.3	13.8	14.1
Idaho	7.2	3.3	10.5
Illinois	3.9	5.4	9.3
Indiana	8.3	4.0	12.4
Iowa	0.8	1.2	2.0
Kansas	8.6	6.9	15.5
Kentucky	11.3	0.0	11.3
Louisiana	11.7	1.5	13.2
Maine	7.3	3.5	10.8
Maryland	1.6	14.2	15.8
Massachusetts	7.9	1.0	8.9
Michigan	3.4	3.9	7.3
Minnesota	3.5	0.0	3.5
Mississippi	15.1	1.2	16.2
Missouri	0.0	14.4	14.4
Montana	11.1	5.7	16.8

* Inconsistencies in totals are due to rounding.

Table 4. *State Hospital Bed Population by Legal Status, continued*

STATE	CIVIL BEDS PER 100,000 POPULATION	FORENSIC BEDS PER 100,000 POPULATION	TOTAL BEDS PER 100,000 POPULATION*
Nebraska	11.7	3.5	15.2
Nevada	7.6	2.6	10.2
New Hampshire	11.9	0.0	11.9
New Jersey	12.0	5.3	17.2
New Mexico	8.9	2.1	11.0
New York	12.6	3.6	16.3
North Carolina	6.5	2.3	8.9
North Dakota	9.9	8.6	18.5
Ohio	3.5	6.1	9.7
Oklahoma	5.9	5.1	11.0
Oregon	5.3	10.9	16.2
Pennsylvania	8.6	1.8	10.4
Rhode Island	9.7	2.7	12.3
South Carolina	3.1	4.4	7.5
South Dakota	14.9	0.0	14.9
Tennessee	7.0	1.5	8.5
Texas	3.7	4.4	8.1
Utah	5.1	3.3	8.4
Vermont	2.4	1.6	4.0
Virginia	14.0	4.2	18.2
Washington	8.2	1.9	10.2
West Virgina	8.9	5.2	14.1
Wisconsin	1.9	6.0	7.9
Wyoming	29.5	4.8	34.3
TOTALS	**6.2**	**5.5**	**11.7**

* Inconsistencies in totals are due to rounding.

Another reason why the public views law enforcement and jails as the most accessible routes for mental health crisis intervention are well-publicized developments like these:

- In California, the Tehama County sheriff and Health Services Agency asked the Board of Supervisors to declare the jail a mental health treatment facility so mentally ill inmates can be medicated over objection there.[53] State law prohibits involuntary medication outside a state hospital or designated facility.
- In Colorado, legislation was under consideration to authorize jails to be used in lieu of hospitals when no bed is available for individuals in psychiatric crisis who have not committed crimes, for up to 48 hours or longer over weekends and holidays.[54]

- In Florida, a mental health court judge told an interviewer from the NASMHPD, "Competency is rarely his primary concern when he orders an evaluation. If there were another means of obtaining quick treatment, he said, he would use it instead." The interviewer concluded, "There is reason to believe that in some states with large numbers of evaluations, referrals serve not only to help determine triability but also as an avenue to treatment for mentally ill persons in jail."[55] It is likely no coincidence that Florida reports the highest number of competency restorations in the country: about 1,550 per year.[56]

There's even jargon for when law enforcement resorts to arrest because treatment isn't available: "mercy bookings."

Sample of the States

As a nation that combines the highest incarceration rate in the world with an incomplete and selective mental health system oriented toward the healthiest patients, the United States perhaps inevitably holds an enormous number of mentally ill individuals behind bars: more than 350,000 on any given day.[57] In 2014, an estimated 1.8 million U.S. jail bookings involved people with serious mental illness.[58] These pretrial offenders made up the majority of inmates in line for forensic beds, and their numbers are exploding. Colorado reported a 500% increase in referrals for pretrial competency evaluations for criminal offenders from 2004 to 2013.[59] Oregon reports that forensic bed demand nearly doubled from 2010 to 2013.[60] In Virginia, forensic admissions to state hospitals rose 13.5% from fiscal year 2014 to 2015.[61] If demand for pretrial forensic services is surging, the logical explanation is that arrests of people with psychiatric symptoms are surging, too. Examining whether and why such a trend might be emerging is beyond the scope of this study but merits investigation, given the significant toll incarcerating individuals with mental illness exacts from them, the criminal justice system and taxpayers.

To sample the impact of bed shortages on forensic patients, the Treatment Advocacy Center collected detailed data from 25 states that are highly populated, being sued or threatened with legal action for nontreatment of mentally ill inmates, and/or actively considering mental health system reforms to increase treatment access (see Table 5). Statutes and regulations were reviewed in the same states to identify public policies that may be associated with their bed trends (see Appendix).

Table 5. *Forensic Bed Trends in 25 Sample States*

STATE	2016 FORENSIC BED CENSUS	# OF INMATES WAITING FOR FORENSIC BED	AVERAGE # OF DAYS FROM WAIT LIST TO ADMISSION	# OF INMATES WAITING PER 100,000 POPULATION	FORENSIC BED OCCUPANCY RATE IN 2015	% OF FORENSIC BEDS OCCUPIED BY NGRI♦	AVERAGE LENGTH OF STAY FOR NGRI (DAYS)	OPENING (++) OR CLOSING (--) BEDS IN THE NEXT 12 MONTHS
California	4,412	418	75	1.4	*	*	*	*
Colorado	184	100	*	2.4	*	68%	3,175.5	n/c
Florida	1,559	44	13	0.3	100%	31%	921.0	++
Georgia	641	72	*	0.9	96%	53%	*	++
Illinois	896	62	38	0.6	112%	60%	2,007.5	n/c
Indiana	267	26	*	0.5	*	8%	1,950.0	

♦ NGRI = People found "not guilty by reason of insanity"
* Information unavailable
^ All of Kentucky's forensic beds are behind bars and not included in census count
+ Patients waiting for beds behind bars
° NGRI patients converted to civil commitment after 180 days

Table 5. *Forensic Bed Trends in 25 Sample States, continued*

STATE	2016 FORENSIC BED CENSUS	# OF INMATES WAITING FOR FORENSIC BED	AVERAGE # OF DAYS FROM WAIT LIST TO ADMISSION	# OF INMATES WAITING PER 100,000 POPULATION	FORENSIC BED OCCUPANCY RATE IN 2015	% OF FORENSIC BEDS OCCUPIED BY NGRI•	AVERAGE LENGTH OF STAY FOR NGRI (DAYS)	OPENING (++) OR CLOSING (--) BEDS IN THE NEXT 12 MONTHS
Kentucky	0^	56+	18+	1.6+	86%+			++
Maine	47	5	7	0.5	94%	20%	925.0	n/c
Maryland	853	75	*	1.6	*	*		*
Massachusetts	70	0	0	0	*	*	180°	*
Michigan	384	120	190	1.6	100%	100%	*	++
Minnesota	0	0	0	0	93%	85%	2,555.0	n/c
New Jersey	471	38	270	0.6	125%	35%	1,787.0	--
New York	720	0	0	0	94%	39%	*	n/c
North Carolina	236	0	0	0	92%	65%	2,956.5	n/c
Ohio	714	9	*	0.1	95%	49%	733.0	n/c
Oklahoma	200	0	0	0	100%	43%	*	--
Oregon	439	0	0	0	91%	55%	945.0	++
Pennsylvania	236	220	180	2.2	*	*	*	--
Tennessee	100	0	0	0	100%	50%	640.0	n/c
Texas	1,216	397	61	2.0	113%	20%	1,001.0	++
Virginia	356	70	73	1.1	90%	64%	*	*
Washington	138	176	43	3.2	*	*	*	++
Wisconsin	349	57	70	1.3	97%	82%	1,095.0	++
Wyoming	28	11	*	2.5	100%	25%	*	n/c
TOTALS	**14,516**	**1,956**			AVERAGE	**50.1%**	**1,591.7**	

• NGRI = People found "not guilty by reason of insanity"
* Information unavailable
^ All of Kentucky's forensic beds are behind bars and not included in census count
+ Patients waiting for beds behind bars
° NGRI patients converted to civil commitment after 180 days

As overwhelming as the volume of referrals is to state hospitals with bed shortages, remarkably few pretrial inmates become candidates for a psychiatric bed stay. Out of the 1.8 million jail bookings in which a mental health condition is identified, the National Judicial Council in 2011–12 reported that 60,000 legal competency evaluations are court ordered annually.[62] Of the evaluated inmates, an estimated 12,000 defendants were found incompetent to stand trial and entitled to treatment to restore their competency.[63] Because most states authorize competency evaluations to be conducted in jails or community settings,[64] these evaluations do not necessarily require hospital stays. Restoration in the community or in jail is also authorized by many states, though it is less widely practiced than outpatient evaluation; the majority of inmates under treatement to restore competency are treated in state hospitals.[65]

However, pretrial inmates are just the tip of the criminal justice iceberg in state hospitals. Also vying for forensic beds:

- Defendants being treated in lieu of conviction ("not guilty by reason of insanity," or NGRI)
- Offenders found guilty but mentally ill, an alternative to acquittal by reason of insanity

- Convicted offenders undergoing presentencing evaluations
- Sentenced offenders in need of treatment, presumably including many of the estimated 30,000 state prisoners with mental illness in solitary confinement
- In some states, sexual offenders

Bed waits for the swelling ranks of pretrial inmates in need of psychiatric services are in part a function of how many state hospital beds are already occupied by subsets of the forensic population who are long-term patients. In the 19 states of our sample that supplied census numbers, NGRI patients occupied 3,882 beds—an average of 50% of all forensic beds in the state hospitals. The impact of NGRI hospitalization on bed access for other patients was intensified by the duration of their NGRI state hospital stays: an average of 1,592 days, or 4 years and 4 months. At the extremes, the shortest stay was 640 days, or a little over 21 months, in Tennessee. The longest was 3,175 days, almost 9 years, in Colorado.

When there are no beds available for forensic services, inmates wait, typically behind bars and without treatment. In 2014, 31 of 40 state hospitals responding to an industry survey reported maintaining forensic waiting lists; 19 of 38 respondent states reported being threatened with or held in contempt of court for failing to admit court-ordered patients in a timely manner.[66] Lawsuits have since been filed in several of them.

Consider these figures from the 25 states the Treatment Advocacy Center sampled:

- Forensic bed occupancy rates in 2015 were at least 90% in every state.
- Approximately 1,950 pretrial inmates were reported in 17 states to be on waiting lists for state hospital beds: California, Colorado, Florida, Georgia, Illinois, Indiana, Maine, Maryland, Michigan, New Jersey, Ohio, Pennsylvania, Texas, Virginia, Washington, Wisconsin and Wyoming. Due to the exigencies of how and where bed waits are tracked, this count is far from comprehensive.
- The number of inmates waiting for pretrial services—competency evaluation or restoration—ranged from 5 inmates in Maine on March 11, 2016, to 397 inmates reported waiting in Texas on April 8, 2016.

"The (Department of Human Services) commissioner is telling us they no longer can comply with the law, and that leaves us with an interesting dilemma. Do we hold inmates illegally in jail, or is the commissioner failing in her public duty and violating a judge's order? The victim in all this is the person with mental illness sitting in jail."

Jim Franklin, executive director of the Minnesota Sheriffs' Association
"County Jails Struggling with Mentally Ill Inmates Left to Languish"
Minneapolis *Star Tribune* (July 21, 2015)

- Average bed waits ranged from a low of 7 days in Maine to a high of 270 days (approximately 9 months) in New Jersey.
- Eight of the 25 states sampled were operating under court orders or the threat of a court order related to their mentally ill inmates: California, Colorado, Oklahoma, Pennsylvania, Texas, Utah, Washington and Wisconsin. A ninth state, Minnesota, is under threat of litigation by county sheriffs, who want state mental health officials to stop violating a state law requiring that mentally ill inmates be transferred to the state hospital within 48 hours of being committed by a judge.[67]
- After adjusting for the role of state population on the number of inmates waiting for beds, Washington had the biggest logjam of mentally ill inmates waiting for a bed: 3.4 inmates per 100,000 adult population waiting for a forensic bed. Ohio had the smallest: 0.1.

- Six states reported no bed waits because civil beds are diverted as needed for forensic purposes: Massachusetts, North Carolina, New York, Oklahoma, Oregon and Tennessee. Minnesota mandates treatment of mentally ill inmates within 48 hours of a court order's being issued and reported no wait list for beds. The fact that Minnesota sheriffs are threatening to sue the state mental health department for failing to admit inmates within the legal time limit suggests that, while official wait lists may not be maintained, inmates in the state are, in fact, waiting for beds.

Grim as this picture is, it should not be mistaken as complete. At best, our survey provides a snapshot of the impact of bed shortages on inmates in America's jails and prisons. Vast additional populations of mentally ill offenders are behind bars but don't "count" as waiting for a bed. At a minimum, these populations include the following:

- An undetermined number of mentally disordered pretrial inmates who haven't yet been targeted for a competency evaluation
- An undetermined number of pretrial inmates who are mentally disordered but are not found to be in need of a psychiatric evaluation or restoration of competency
- An undetermined number of inmates who meet the legal standard for competence but are not clinically stable
- An undetermined number of inmates who are segregated in "mental health pods" reserved for mentally ill prisoners behind bars, where "treatment" may consist of daily medications and a monthly check-in through the bars by a psychiatrist
- Several thousand inmates in high-security psychiatric units on prison grounds
- An undetermined number of the estimated 30,000 mentally ill inmates housed in solitary confinement because their symptoms render them unable to live in the general prison population
- An undetermined number of other prisoners with mental illness who fit none of the categories above

It is far easier to count the number of beds available for forensic patients than the number of people who would benefit from them. What is undeniable is that demand vastly outstrips supply, with devastating consequences to the inmates, the jail and prison personnel who manage them, and taxpayers.

"Detention in a prison is not treatment. It is custodial management. It also is inconsistent with the concept of 'milieu' referring to a therapeutic environment. Department of Corrections leaders are not subject matter experts on the treatment of the mentally ill. We must be vigilant to protect vulnerable individuals from a corrections paradigm being substituted for a behavioral health treatment one."

Beatrice Coulter, registered nurse
"The Trouble with New Hampshire's Secure Psychiatric Unit"
Concord Monitor (February 28, 2016)

DISCUSSION

The Treatment Advocacy Center issued state bed surveys in 2008, 2010 and 2012. In each, we reported double-digit declines in state hospital bed censuses. We called for repealing or reforming the discriminatory exclusion of institutions for mental disease from Medicaid payments (the IMD Exclusion), promoting wider use of hospital-diversion strategies such as assisted outpatient treatment (AOT) and assertive community treatment (ACT), and raising awareness and accountability for the association between hospital bed shortages and social problems such as the criminalization of mental illness. We additionally called for a moratorium on further public hospital bed closures until a sufficient number of beds are created to meet inpatient needs.

Noteworthy progress has been made since 2012 toward the first three recommendations.

- In April 2016, the Centers for Medicare and Medicaid Services issued a final rule partially repealing the IMD Exclusion's restrictions on managed care organizations. They are now authorized to provide up to 15 days of acute psychiatric care in a month to Medicaid enrollees. While not extending to state or county hospitals or other IMDs, the rule is expected to improve access for impoverished psychiatric patients by making it economically viable for additional psychiatric facilities to admit them. At the same time, final evaluation and a report to Congress on a demonstration of waiving the IMD Exclusion is forthcoming under provisions of the Affordable Care Act. Preliminary findings already reported were positive.
- Two additional states—Nevada in 2013 and New Mexico in 2016—authorized the use of AOT for qualifying patients, New Jersey funded AOT implementation in every county statewide, and Congress in 2015 appropriated $15 million to jump-start up to 50 new AOT programs nationwide. ACT teams in 2012 were reported to be available in at least 42 states[68] and continue to be activated in additional communities.
- Emergency room boarding, forensic bed waits and tragedies resulting from bed shortages are now routinely reported in the media and reflected in public opinion and pressure on lawmakers. Ninety-five percent of the state mental hospital directors responding to a 2014 survey about forensic services said the public in their states had "very strong" or "somewhat strong" concerns about the "very large presence of people with mental disorders in the nation's jails and prisons."[69] Provisions to improve treatment access and reduce the criminalization of mental illness have been included in all the major mental health reform and criminal justice reform bills introduced in Congress and proposed legislation in almost every state.

"While many academic researchers and even governmental regulatory agencies such as the Department of Health and Human Services (DHHS) have looked at the issue of boarding, all have identified a relatively common culprit—a mismatch between supply and demand. This simple, yet doomed equation of shrinking psychiatric patient resources with an ever-expanding psychiatric patient population represents the main cause for reduced psychiatric patient capacity in the emergency deparment."

American College of Emergency Physicians
Care of the Psychiatric Patient in the Emergency Department: A Review of the Literature
(October 2014)

These are all to the good, but the United States has dug itself a mental illness treatment hole that will take more than a few shovelfuls of additional beds and an occasional enlightened policy or court order to fill. Given the numbers of mentally ill prisoners and boarded ER patients—not to mention the homeless, the victims of violence and all the other people suffering consequences of nontreatment—more beds are urgently needed, and a moratorium to save the scant number that remain is critical before these, too, are gone.

Strategies for Reducing Demand

Our sample identified a number of states attempting to alleviate shortages with policies aimed at reducing demand for state hospital beds. Although evaluation of their effectiveness is beyond the scope of this study, and no endorsement is implied, the following strategies merit examination for their effectiveness in meeting patient need while relieving shortages and containing costs. By serving patients in outpatient settings, the first three would have the added value of providing treatment in less restrictive settings.

- **Conducting psychiatric evaluations of legal competency in the community**
  Outpatient competency evaluations are authorized by law and conducted in most states, but courts may still order offenders to be evaluated in a hospital.[71] In our survey, 14 of the 25 states legally authorized evaluations in the community without restriction, 3 authorized them with conditions (e.g., if the defendant is entitled to community release), 6 did not address the issue or left it unclear, and 2 prohibited evaluation in the community.

- **Conducting competency evaluations in the jail**
  Most authorities say the "vast majority" of competency evaluations can be completed in one or two interviews with the defendant.[72] Perhaps with this in view, more states in our sample—19 of the 25—authorized evaluations in jail than authorized them in the community, with state law silent or unclear in 5 more states. Only Georgia prohibited the practice.

- **Conducting restoration of competency in the community**
  Historically, all offenders were hospitalized for treatment to restore their competency to stand trial, and the vast majority today continue to be restored in state hospitals.[73] Many states report the largest group of defendants they serve in state hospitals are those found incompetent to stand trial, with stays that usually exceed 2 months and can last a year or more.[74] In our sample, 19 states authorize community restoration. The laws in 6 states are unclear; only 2 states—Kentucky and Wyoming—prohibit it.

- **Contracting with community hospitals with psychiatric units to serve the state hospital population**
  North Carolina has increased access to psychiatric beds for uninsured patients in crisis by contracting and funding short-term psychiatric crisis services and detoxification in community hospitals.[75] Rhode Island supplies 130 "state hospital" beds in a general hospital. A Rhode Island official told our interviewer that one of the benefits of this strategy was qualifying state beds for Medicaid reimbursement by maintaining them in a facility that can collect insurance rather than in a state hospital that can't.

- **Maintaining bed registries**
  Some of the most widely publicized tragedies associated with bed shortages—including the death of Jamycheal Mitchell—occurred when public psychiatric beds were, in fact, available but not identified because of systemic disorganization or human error. Matching people who are waiting with beds that are open improves bed access and treatment. Bills to create bed registries have been passed or are before legislatures in multiple states. Early results have shown decreased bed waits where they are operated efficiently.

The uneven use of such strategies suggests many states have unrealized opportunities to address their bed shortages with public policy reform. Like the ideal of deinstitutionalization itself, these policies would be best implemented after careful examination of the evidence and local conditions for implementing them. For example, competency restoration in the community is an alternative only where appropriate clinical services to provide it are available.

Obstacles to Balancing Bed Supply with Demand

Our review also identified public policies that appear to create obstacles to balancing bed supply and demand and thus represent additional opportunities for reform. Among them are the following five.

- **Bail requirements**

  Often unemployed and impoverished, mentally ill offenders are overrepresented among low-level defendants accused of petty crimes. At the same time, they are less likely to be released on bail than other inmates and spend more time behind bars before posting bail. An analysis of mental illness in New York City jails in 2012 found mentally ill inmates took five times longer than other inmates to make bail.[76] Half of the states in our sample explicitly or likely required inmates to post bail before they could be released for restoration in the community (see Appendix). For many mentally disordered offenders, this creates an insurmountable obstacle to outpatient restoration and guarantees they will require a state hospital bed. Reducing barriers to community mental health services for nonviolent offenders accused of low-level crimes would reduce demand for state hospital beds.

- **Public assistance practices**

  In most states, access to public assistance such as Medicaid is automatically terminated when an individual is detained or incarcerated, and the inmate must re-enroll after discharge. This causes delays in receiving medication and other mental health services and can pose an insurmountable bureaucratic hurdle for people arrested because of untreated psychiatric symptoms, which often worsen while they remain untreated in the stressful jail environment. Termination of coverage also is believed to contribute to the two to three times greater risk of rearrest for mentally ill inmates.[77] Some states are taking steps to suspend rather than terminate Medicaid benefits during incarceration and reinstate coverage upon jail discharge to close this gap to reduce this consequence.

- **Length-of-stay practices**

  Psychiatric hospital stays have shrunk to 7.2 days in the United States on average,[78] but the length of forensic hospital stays is typically far longer, and the conditions of discharge may be dictated by state law or the courts rather than clinical need (see Appendix). In the NASMHPD forensic survey of 2014, 43% of the responding state hospitals said they may release a defendant as soon as a competency evaluation is completed; 57% said they could not. The resulting average length of stay for an evaluation ranged from 0 to 1 month in 12 states and more than 6 months in 1 state.[79] Our sample of states found a limit of 60 days for competency restoration of accused felons in Pennsylvania, 120 days in Texas and 3 years in California. Converted into bed demand, this means 18 times as many forensic patients could be hospitalized for the maximum restoration stay in Pennsylvania as in California over a three-year period. In some states, pretrial offenders spend longer waiting for or receiving competency services than they would be sentenced if convicted of their crimes.

- **Discharge and release practices**

  The longer existing patients remain in the hospital, the fewer new patients can be admitted. In Virginia, for example, an estimated 150 people had been on the commonwealth's "extraordinary barriers to discharge list" of state hospital patients considered "clinically ready for discharge" for more than 30 days in November 2015, and another 60 to 70 had been in the category for up to one month. In other words, about 20% of the state's psychiatric bed population was occupied by patients considered clinically stable who had nowhere to go if they were discharged.[80] It is another sad irony of America's dysfunctional mental health system that acutely ill patients who would benefit from short-term intervention are left to become sicker because of long-stay patients deemed ready to leave the hospital if they had access to an appropriate step-down level of care.

- **Sexual predator confinement**

  Twenty states and the District of Columbia have laws providing for the civil commitment of certain sexual offenders (often called "sexually violent offenders") after they complete their sentences, whether they are in need of treatment or not.[81] They are held in a variety of settings, including state hospitals, which spent an estimated 5% of their budgets on sex offenders in 2010.[82] NASMHPD, the American Bar Association and other organizations have criticized and called for reform of these policies on civil liberty and other grounds. Where they continue, they reduce hospital bed access for civil and other forensic patients who do need treatment.

RECOMMENDATIONS

More meaningful treatment legislation has been introduced in the last two congressional sessions than in the previous half-century, an encouraging sign. Less encouraging: Not one has passed. In addition to enacting the reforms in these bills, we recommend the following actions to stem the devastating trends and consequences of America's dire psychiatric hospital bed shortage.

1. **Determine how many psychiatric beds are needed to meet inpatient need and set supply targets**

   With lawsuits and court orders proliferating over illegal boarding of psychiatric patients in hospital ERs and bed waits in jails, there is little doubt the United States needs more psychiatric beds to meet inpatient demand. Psychiatric literature converges around an optimal estimated supply of 40 to 60 psychiatric beds per 100,000 population, and 50 beds per 100,000 population is widely used as a rule of thumb. Researchers at Duke University have created a simulation model to analyze how many nonforensic beds would be needed to reduce the amount of time people in psychiatric crisis currently spend waiting for a hospital bed.[83] Denmark operates a psychiatric case registry that enables the nation to monitor the association of deinstitutionalization with higher rates of incarceration. It is time to build on existing data-mining technologies to develop evidence-based bed targets that recognize the role of subpopulations (e.g., juvenile, adult, geriatric, civil, forensic, acute, long-term) and facility types (e.g., public, private, crisis/respite, residential). In recognition of the national scope and impact of the bed shortage and the need for baseline data nationwide and tools for setting targets, the federal government should undertake an assessment of hospital bed need by type, facility and location, and advance the use of tools such as Duke University's computer modeling to develop realistic hospital bed targets.

2. **Identify and reform public policies that exacerbate bed shortages**

   The 50-year-old exclusion of IMDs from Medicaid reimbursement outside of 16-bed facilities created a discriminatory economic incentive for denying care to impoverished mentally ill citizens between the ages of 21 and 64. The new rule that partially repeals the IMD Exclusion by expanding Medicaid reimbursement to managed care organizations is an important first step. But Congress needs to end this discriminatory treatment of mental illness by repealing the IMD Exclusion altogether and enforcing parity so that hospital treatment of psychiatric disease is funded the same way as inpatient care for other medical and surgical disorders. Expanding the IMD rule to cover all Medicaid enrollees, without artificial restriction on length of stay, would help states create new beds, open existing beds that are approved but unstaffed and incentivize other IMDs to accept Medicaid patients. For the benefit of patients, their communities and taxpayers, Congress should direct and fund appropriate agencies to undertake a comprehensive review to identify all federal policies that create financial incentives to close psychiatric beds and assess their economic and other impacts in light of costs to law enforcement, corrections, courts, homelessness services and other public domains affected when mentally ill citizens do not receive needed inpatient services. To address the critical and worsening shortage of psychiatric professionals, the federal government also needs to adopt incentives for medical students to study and practice psychiatry, especially in less populated regions, just as it has incentivized medicine to address other public health shortages in the past. At the state level, legislatures need to undertake economic studies of the net cost taxpayers incur from bed shortages and use these findings to create dedicated funding sources for public investments in new beds—the same mechanisms used to fund other necessary infrastructure projects such as bonds, specifically directed taxes and focused trust funds.

3. **Improve data collection associated with bed shortages and build public policy on the evidence**

   States have experimented with and implemented many strategies in their efforts to reduce demand for state psychiatric beds and treat more patients in less restrictive settings. A few, like New Hampshire's incarceration of civil patients, are giant steps in the wrong direction, raising constitutional and civil rights concerns. Others are more enlightened approaches that remain widely authorized but not widely used. Conducting more competency evaluations in jails or in the community, providing competency restoration in the community, and reexamining length–of–stay requirements and practices are among them. States should gather and assess evidence for strategies that reduce bed demand, identify statutory and regulatory obstacles to implementing such policies, and reform their practices in such a way that demand and supply are better balanced. At the same time, the National Institute of Mental Health (NIMH) should fund outcome research to study the impact of mental health policies on people with serious mental illness. The public health departments of universities should incentivize doctoral and other research projects that contribute to the body of knowledge and the public good about psychiatric issues, including bed shortages.

4. **Increase the use of diversion strategies that reduce hospitalization rates**

   Tools and strategies have been developed that reduce the likelihood that people with serious mental illness will become hospital patients or jail inmates waiting for a bed. None is implemented universally; some are barely used at all. The following three evidence-based practices are associated with reducing emergency room visits and psychiatric hospitalizations. Widely implementing them would help reduce the impact of bed shortages.

   a. Assisted outpatient treatment (AOT): A treatment option that utilizes a court order to require adherence to treatment for individuals with a history of nonadherence and rehospitalization or reincarceration, among other criteria. Authorized in 46 states and the District of Columbia, AOT has been deemed an evidence-based treatment effective in reducing the incidence and duration of hospitalization, homelessness, arrests and incarcerations, victimization and violent episodes.[84]

   b. Assertive community treatment (ACT, which may be included in AOT or independent): A multidisciplinary team approach to serving mentally ill patients where they live. One of the oldest and most widely researched practices in behavioral health care for serious mental illness, ACT decreases client use of intensive, high-cost services such as emergency department visits, psychiatric crisis services and psychiatric hospitalization. Clients of ACT are also more likely to be living independently and have higher rates of treatment retention.[85]

   c. Sequential Intercept Model: A conceptual framework for preventing individuals with mental illness from entering or penetrating deeper into the criminal justice system. Among the intercepts are practices such as mobile crisis teams, which integrate law enforcement and mental health workers to respond to psychiatric calls, and crisis intervention training (CIT), which gives law enforcement specialized training in spotting and responding to individuals in psychiatric crisis.[86] CIT has been shown to significantly increase the likelihood a law enforcement contact with a person with serious mental illness will result in transport to a treatment facility rather than arrest and booking.[87]

ACKNOWLEDGMENTS

Going, Going, Gone is the latest reflection of Dr. E. Fuller Torrey's determined effort to assure that the dire trends and consequences of closing of America's last-resort hospitals are not overlooked, ignored or understated.

Since 2008, the state surveys Dr. Torrey has conducted for the Treatment Advocacy Center have served as the most accessible and reliable state hospital bed resource available and often the only source of complete state-specific bed data about the dwindling state hospital population. With Dr. Torrey's continued technical and editorial guidance, *Going, Going, Gone* continues this legacy of keeping a spotlight on an issue of critical importance to public health and safety and the well-being of countless men and women living with the most severe psychiatric diseases.

Ted Lutterman and the National Association of State Mental Hospital Program Directors Research Institute, where he is senior director of research, continue to be incomparable sources of state hospital data. Julie Plyler, J.D., M.P.H., made a significant contribution with her detailed and careful identification of the laws and regulations that contribute to or mitigate state hospital bed shortages. The photographs contributed by Nancy West, New Hampshire Center for Public Interest Journalism, are worth many thousands of words.

Research and publication of *Going, Going, Gone* were made possible with generous funding from the Val A. Browning Foundation as part of its ongoing support of improved treatment access for some of the nation's most vulnerable citizens.

APPENDIX

Public Policies Impacting Bed Trends in 25 Sample States

STATE	COMMUNITY PSYCHIATRIC EVALUATION?	JAIL PSYCHIATRIC EVALUATION?	COMMUNITY RESTORATION?	JAIL RESTORATION?	UNDER LITIGATION?	CONSENT DECREE OR SETTLEMENT AGREEMENT?
California	N/A	Yes	Yes*	Yes*	Yes	Yes
Colorado	Yes	Yes	Yes°	Yes	Yes	No
Florida	Yes	N/A	Yes°	Yes	No	Yes
Georgia	Yes*	No	Yes*°	No	No	Yes
Illinois	Yes	Yes	Yes°	No	No	Yes
Indiana	N/A	N/A	Yes	Yes	No	Yes
Kentucky	Yes	Yes	No	No	Yes	No
Maine	Yes	Yes	Yes	No	No	Yes*
Maryland	Yes	Yes	Yes*°	No	No	No
Massachusetts	Yes*	Yes	Yes	Yes	Yes	No
Michigan	Yes*	Yes	Yes	Yes	No	No
Minnesota	Yes*	N/A	Yes*	No	No	No
New Jersey	No	Yes*	Yes*	No	No	Yes
New York	Yes	Yes	Yes	N/A	No	Yes
North Carolina	N/A	N/A	Yes°	Yes	No	Yes
Ohio	Yes	Yes	Yes°	N/A	No	No
Oklahoma	Yes	Yes	Yes	Yes	No	Yes
Oregon	N/A	N/A	Yes	N/A	No	No
Pennsylvania	Yes	Yes	Yes	Yes	No	Yes
Tennessee	Yes	N/A	Yes*	Yes	No	No
Texas	Yes*	Yes	Yes°	Yes*	No	Yes
Virginia	Yes	Yes	Yes°	Yes	Yes	No
Washington	Yes	Yes	Yes°	Yes	Yes	Yes
Wisconsin	No	Yes	Yes	Yes	Yes	No*
Wyoming	Yes	Yes	No	No	No	Yes

* Conditional
° Bail required

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The Treatment Advocacy Center is a national nonprofit organization dedicated exclusively to eliminating barriers to the timely and effective treatment of severe mental illness. The organization promotes laws, policies and practices for the delivery of psychiatric care and supports the development of innovative treatments for and research into the causes of severe and persistent psychiatric illnesses, such as schizophrenia and bipolar disorder.

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Response to TDMHSAS

REPORT

Erlanger Behavioral Health, LLC

Applicant Comments To HSDA Pertaining To CON Application
For A New Behavioral Health Hospital (No. CN1603-012)

The *Tennessee Department Of Mental Health and Substance Abuse* ("*TDMHSA*") submitted its findings to the Tennessee Health Services and Development Agency (HSDA) following a review of the CON application filed by Erlanger Behavioral Health, LLC for a new behavioral health hospital to be located in Hamilton County, Chattanooga, Tennessee, on June 28, 2016. Following are comments by the applicant, Erlanger Behavioral Health, LLC in response to the *TDMHSA* report.

Report of Tennessee Dept. Of Mental Health and Substance Abuse

TDMHSA has recommended approval of the CON application by the *Tennessee Health Services & Development Agency* ("*HSDA*"). *TDMHSA* states that the application addresses the priorities detailed in the Tennessee State Health Plan in that it "promotes these principles through addition of specialized healthcare" (p. 13, para. 3), that it " contributes to the orderly development of healthcare" and will "have a positive impact on the community and the mental health delivery system" (p. 15, para. 6).

The *TDMHSA* report includes an evaluation of need based on "staffed beds" as defined in the *Tennessee Joint Annual Report* ("*JAR*"), "the total number of adult and pediatric beds set up, staffed and in use" (p. 2, para. 4). "Staffed beds" is an appropriate measure of available bed supply as the full complement of "licensed beds" may not otherwise be available for use by patients for a number of reasons, including use of bed space for other services, use of semi-private rooms for private beds, etc. The *TDMHSA* analysis of bed need included in the current supply of staffed beds *River Park Hospital* (10 beds) and *Starr Regional Medical Center* (10 beds); Starr Regional reported 7 geriatric psychiatric beds in their 2014 JAR Report with these beds operating at 114% occupancy (attached). River Park Hospital reported zero (0) staffed beds for Psychiatric Services in their 2014 JAR's (attached). Also, the *TDMHSA* report only included forty eight (48) beds for *Parkridge Valley Adult Hospital*; however, this facility actually has sixty-four (64) licensed psychiatric hospital beds. The *TDMHSA* report stated that *Parkridge West Hospital* closed on April 4, 2016 … while the medical / surgical component has closed … the behavioral health unit with twenty (20) beds is reported to be open. Finally, the *TDMHSA* report also listed the total population for the Tennessee portion of the service area as 1,218,509; however, we believe the correct population for 2016 is 1,015,247 and 1,049,445 for 2020 (attached; Boyd Center for Business & Economic Research, Haslam College of Business,

University of Tennessee/Knoxville). With these items considered, an adjusted bed need calculation follows below.

	Total Psych / SA	== Total Psych / Chemical Beds Reported By Erlanger == Child & Youth	Adult Psych	Geriatric	Chemical Dependency	Total	Total Beds Reported By TDMH
Parkridge Valley Adult - Chattanooga, TN	108	108				108	108
Parkridge Valley Child / Adolescent - Chattanooga, TN	64		32	16	16	64	48
Parkridge West Hospital - Jasper, TN	20		20			20	0
Erlanger North Hospital - Chattanooga, TN	12			12		12	12
Moccasin Bend MHI - Chattanooga, TN	150		150			150	150
Skyridge Medical Center - Westside - Cleveland, TN	29		29			29	30
Southern Tenn Med Ctr - Winchester, TN	12		12			12	12
Starr Regional Med Ctr - Etowah, TN	10			10		10	10
River Park Hospital - McMinnville, TN	0					0	10
Hamilton Medical Center - Dalton, GA	7		7			7	7
DeKalb Regional Medical Center - Fort Payne, AL	18			18		18	18
Total	430	108	250	56	16	430	405

	==== Pop. Est. 2016 ==== Tenn.	Non-Tenn.	== Pop. Est. 2020 === Tenn.	Non-Tenn.
Child (Age 0-14)	172,951	111,190	171,916	105,829
Adolescent (Age 15-17)	42,402	24,437	45,217	27,099
Adult (Age 18-64)	595,632	344,981	598,660	343,305
Geriatric (Age 65+)	203,262	97,806	233,652	108,586
	1,015,247	578,414	1,049,445	584,819
Total Est. Psychiatric Bed Need - 2016	478			
Total Est. Psychiatric Bed Need - 2021	490			

	== Est. Beds Required == 2016	2020	Current Supply	==== Est. Need ==== 2016	2020	Proposed Bed Mix
Child / Adolescent Beds - Est. Need - 2016	105	105	108	-3	-3	18
Adult Beds - Est. Need - 2016	282	283	266	16	17	46
Geriatric Beds - Est. Need - 2016	90	102	56	34	46	24
Total	477	490	430	47	60	88

(**) Substance Abuse beds included in Adult Psychiatric beds.

The table above reflects a net need of forty-seven (47) beds for the service area in 2016, and sixty (60) beds in 2020, including the 12 psychiatric beds at Erlanger North to be transferred to the new hospital, net of occupancy or access considerations. While the proposed facility is eighty-eight (88) beds, a need remains for the additional beds … as stated by *TDMHSA*, "application of the formula sometimes results in an under estimation of the number of inpatient psychiatric beds needed" (p. 2, para. 3). Further, *TDMHSA* is correct in stating that "other factors are relevant for consideration" (p. 6, para.5). Specifically, the occupancy rate for *Moccasin Bend Mental Health Institute* ("*MBMHI*") is 91.1%, and for the other mental health hospitals in Hamilton County is 82.8%. In addition, "Parkridge Valley does not accept uncompensated care patients and some involuntary admissions, but only those with insurance" (p. 6, para. 5).

The *TDMHSA* report incorrectly stated that Erlanger's amount of cash on hand was $11.215 million; the correct amount from the FY 15 audited financial statement is $92.64 million.

In addition, the *TDMHSA* report identified three (3) sub-acute providers of chemical dependency detoxification services (p. 3, Chart – "Other Detox Beds"). While these beds were not included in the bed need calculation by *TDMHSA*, we think the comparison is not appropriate because these are essentially community based "step down" beds, which are not interchangeable with or licensed as acute psychiatric beds. They do not provide the same level of services. We have similar concerns about use of these beds by patients with co-morbid medical and behavioral health conditions, those who are suicidal as well as by women in the third trimester of pregnancy given the high risk to newborns and the alarming rate of neonatal abstinence syndrome.

One of the non-hospital providers which *TDMHSA* identified was the *Council for Alcohol & Drug Abuse Services* ("*CADAS*") with 12 detox beds. On the *CADAS* website, the level of care which they self- identify as providing is "medically monitored detoxification", which is Level III.7-D according to the website for the *American Society of Addiction Medicine* ("*ASAM*") . This level of care is significantly different from the level of care which will be provided by *Erlanger Behavioral Health*, which is Level IV-D and appropriately described as Medically Managed Intensive Inpatient Detoxification. As may be seen from this illustration, there is a significant difference between "*medically monitored*" and "*medically managed intensive*" levels of care. These levels of care are rightfully differentiated given the nature of the patients served and the resources utilized for these patients. The non-hospital providers also do not treat Medicare patients because the *Centers For Medicare & Medicaid Services* ("*CMS*") does not certify these beds and does not reimburse for the lower level of "step down" care; Medicare only reimburses for services rendered in certified acute facilities which *EBH* will provide. Accordingly, we do not think the comparison of the non-hospital providers by *TDMHSA* was appropriate.

4. A. Number of Beds Set Up and Staffed on a typical day

SERVICE	BEDS
Medical	0
Surgical	0
Medical/Surgical	0
Obstetrics	0
Gynecological	0
OB/GYN	0
Pediatric	0
Eye	0
Neonatal Care	0
Intensive Care (excluding Neonatal)	0
Orthopedic	0
Urology	0
Rehabilitation	0
Chronic/Extended Care	0
Pulmonary	0
Psychiatric	7
Psychiatric specifically for Children and Youth under age 18	0
Psychiatric specifically for Geriatric Patients	7
Chemical Dependency	0
Chemical Dependency specifically for Children and Youth under age 18	0
Chemical Dependency specifically for Geriatric Patients	0
Swing Beds (for long term skilled or intermediate care)	0
Other, specify	0
Unassigned	0
TOTAL	7

STAFF REGIONAL

B. Number of Patients in hospital on a typical day. Exclude normal newborns (See Instructions), long term skilled or intermediate patients. 8

5. OBSERVATION BEDS

A. Do you use inpatient staffed beds for 23-hour observation? ○ YES ◉ NO If yes, number of beds 0

B. Do you have beds assigned to dedicated 23-hour observation unit? ○ YES ◉ NO If yes, number of beds 0

C. Do you have beds in a "same-day-surgery" unit that are used for both same-day surgery and 23-hour observation? ○ YES ◉ NO
If yes, number of beds 0

SCHEDULE G - UTILIZATION* State ID 54233

1. INPATIENT UTILIZATION (include normal newborns)
   Patient Census Records:
   Please indicate whether you are reporting Admissions and Inpatient Days ◉
   or Discharges and Discharge Patient Days ○

2. UTILIZATION BY MAJOR DIAGNOSTIC CATEGORIES:

MAJOR DIAGNOSTIC CATEGORIES	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS
01 Nervous System	21	75
02 Eye	0	0
03 Ear, Nose, Mouth and Throat	5	13
04 Respiratory System	88	292
05 Circulatory System	47	131
06 Digestive System	22	72
07 Hepatobiliary System & Pancreas	5	17
08 Musculoskeletal Sys. & Connective Tissue	4	21
09 Skin, Subcutaneous Tissue & Breast	5	21
10 Endocrine, Nutritional & Metabolic	18	48
11 Kidney & Urinary Tract	24	70
12 Male Reproductive System	1	2
13 Female Reproductive System	0	0
14 Pregnancy, Childbirth & the Puerperium	0	0
15 Normal Newborns & Other Neonates with Conditions Originating in the Perinatal Period	0	0
16 Blood and Blood Forming Organs and Immunological Disorders	5	14
17 Myeloproliferative Disorders & Poorly Differentiated Neoplasms	0	0
18 Infectious & Parasitic Diseases	14	46
19 Mental Diseases & Disorders	257	2,925
20 Alchohol/Drug Use & Alcohol/Drug-Induced Organic Mental Disorders	1	3
21 Injuries, Poisoning, & Toxic Effects of Drugs	4	8
22 Burns	0	0
23 Factors Influencing Health Status and Other Contacts with Health Services	2	8
24 Multiple Significant Trauma	0	0
25 Human Immunodeficiency Virus Infections	0	0
26 Other DRGs Associated with All MDCs	0	0
TOTAL	523	3,766

SMAR Regional

REPORT 2A
REPORT FOR HOSPITALS 2014

HOSPITALS LICENSED IN TENNESSEE
SELECTED UTILIZATION BY TYPE OF HOSPITAL

SOUTHEAST REGION

County	Facility	Type of Service	Staffed Beds	Discharge/ Inpatient Days	Staffed Bed Days Open	Staffed Beds Percent Occupancy	Licensed Beds	Licensed Bed Days Open	Licensed Beds Percent Occupancy	Discharges or Admissions	Average Length of Stay	Average Daily Census
GENERAL HOSPITALS, SPECIALTY HOSPITALS, MEDICAL CENTERS												
REGION TOTAL			529	84,199	193,085	43.6	859	313,535	26.9	18,369	4.6	231
Bledsoe	Erlanger Bledsoe	Other	25	1,687	9,125	18.5	25	9,125	18.5	289	5.8	5
Bradley	Skyridge Medical Center	Med-Surg	156	31,708	56,940	55.7	251	91,615	34.6	7,117	4.5	87
	Skyridge Medical Center Westside	Med-Surg	30	4,107	10,950	37.5	100	36,500	11.3	841	4.9	11
Franklin	Southern Tennessee Regional Health System - Sewanee	Med-Surg	21	1,532	7,665	20.0	21	7,665	20.0	432	3.5	4
	Southern Tennessee Regional Health System - Winchester	Med-Surg	103	18,277	37,595	48.6	152	55,480	32.9	3,874	4.7	50
McMinn	Starr Regional Medical Center	Med-Surg	63	8,365	22,995	36.4	118	43,070	19.4	2,285	3.7	23
	Starr Regional Medical Center Etowah	Med-Surg	45	3,766	16,425	22.9	72	26,280	14.3	523	7.2	10
Marion	Grandview Medical Center Jasper	Med-Surg	36	7,587	13,140	57.7	70	25,550	29.7	1,200	6.3	21
Polk	Copper Basin Medical Center	Med-Surg	25	3,644	9,125	39.9	25	9,125	39.9	791	4.6	10
Rhea	Rhea Medical Center	Med-Surg	25	3,526	9,125	38.6	25	9,125	38.6	1,017	3.5	10

River Park Hospital
JAR - 2014

4. A. Number of Beds Set Up and Staffed on a typical day

SERVICE	BEDS
Medical	0
Surgical	0
Medical/Surgical	86
Obstetrics	6
Gynecological	0
OB/GYN	0
Pediatric	0
Eye	0
Neonatal Care	0
Intensive Care (excluding Neonatal)	8
Orthopedic	0
Urology	0
Rehabilitation	15
Chronic/Extended Care	0
Pulmonary	0
Psychiatric	0
Psychiatric specifically for Children and Youth under age 18	0
Psychiatric specifically for Geriatric Patients	0
Chemical Dependency	0
Chemical Dependency specifically for Children and Youth under age 18	0
Chemical Dependency specifically for Geriatric Patients	0
Swing Beds (for long term skilled or intermediate care)	10
Other, specify	0
Unassigned	0
TOTAL	125

B. Number of Patients in hospital on a typical day. Exclude normal newborns (See Instructions), long term skilled or intermediate patients. 31

5. OBSERVATION BEDS

A. Do you use inpatient staffed beds for 23-hour observation? (•) YES ( ) NO If yes, number of beds 4

B. Do you have beds assigned to dedicated 23-hour observation unit? ( ) YES (•) NO If yes, number of beds 0

C. Do you have beds in a "same-day-surgery" unit that are used for both same-day surgery and 23-hour observation? ( ) YES (•) NO
If yes, number of beds 0

REPORT 2A
REPORT FOR HOSPITALS 2014

HOSPITALS LICENSED IN TENNESSEE
SELECTED UTILIZATION BY TYPE OF HOSPITAL

UPPER CUMBERLAND REGION

County	Facility	Type of Service	Staffed Beds	Discharge/ Inpatient Days	Staffed Bed Days Open	Staffed Beds Percent Occupancy	Licensed Beds	Licensed Bed Days Open	Licensed Beds Percent Occupancy	Discharges or Admissions	Average Length of Stay	Average Daily Census
GENERAL HOSPITALS, SPECIALTY HOSPITALS, MEDICAL CENTERS												
REGION TOTAL			861	141,335	314,265	45.0	1,037	378,505	37.3	31,530	4.5	387
Cannon	Stones River Hospital	Med-Surg	50	4,816	18,250	26.4	60	21,900	22.0	794	6.1	13
Clay	Cumberland River Hospital	Med-Surg	34	4,072	12,410	32.8	36	13,140	31.0	609	6.7	11
Cumberland	Cumberland Medical Center	Med-Surg	122	24,244	44,530	54.4	189	68,985	35.1	5,489	4.4	66
DeKalb	DeKalb Community Hospital	Med-Surg	56	3,363	20,440	16.5	71	25,915	13.0	940	3.6	9
Fentress	Jamestown Regional Medical Center	Med-Surg	75	7,099	27,375	25.9	85	31,025	22.9	1,647	4.3	19
Macon	Macon County General Hospital	Med-Surg	25	3,121	9,125	34.2	25	9,125	34.2	817	3.8	9
Overton	Livingston Regional Hospital	Med-Surg	82	14,233	29,930	47.6	114	41,610	34.2	2,611	5.5	39
Putnam	Cookeville Regional Medical Center	Med-Surg	243	57,110	88,695	64.4	247	90,155	63.3	13,393	4.3	156
Smith	Riverview Regional Medical Center South	Other	25	6,294	9,125	69.0	25	9,125	69.0	1,183	5.3	17
Warren	River Park Hospital	Med-Surg	125	11,341	45,625	24.9	125	45,625	24.9	2,935	3.9	31
White	Highlands Medical Center	Med-Surg	24	5,642	8,760	64.4	60	21,900	25.8	1,112	5.1	15
MENTAL HEALTH INSTITUTES, MENTAL HEALTH CENTERS												
REGION TOTAL			38	5,060	13,870	36.5	38	13,870	36.5	879	5.8	14
Putnam	PremierCare Tennessee, Inc.	Psych	38	5,060	13,870	36.5	38	13,870	36.5	879	5.8	14

Population For Service Area

	Total Pop. CY 2016	Total Pop. CY 2020	0-17 Pop. CY 2016	0-17 Pop. CY 2020	18+ Pop. CY 2016	18+ Pop. CY 2020	65+ Pop. CY 2016	65+ Pop. CY 2020	18-64 Pop. CY 2016	18-64 Pop. CY 2020
Hamilton County, TN	356,156	368,666	77,582	80,402	278,574	288,264	61,073	69,752	217,501	218,512
Bradley County, TN	105,549	109,706	23,615	23,841	81,934	85,865	17,879	20,381	64,055	65,484
Marion County, TN	28,585	28,633	5,911	5,703	22,674	22,930	5,763	6,584	16,911	16,346
Grundy County, TN	13,470	13,263	2,882	2,695	10,588	10,568	3,021	3,339	7,567	7,229
Sequatchie County, TN	15,835	16,943	3,407	3,501	12,428	13,442	3,195	3,896	9,233	9,546
Bledsoe County, TN	13,273	13,481	2,601	2,546	10,672	10,935	2,628	2,955	8,044	7,980
Rhea County, TN	33,934	35,216	7,677	7,606	26,257	27,610	6,589	7,571	19,668	20,039
Meigs County, TN	12,221	12,462	2,352	2,220	9,869	10,242	2,677	3,151	7,192	7,091
McMinn County, TN	54,449	55,724	11,636	11,592	42,813	44,132	11,089	12,650	31,724	31,482
Polk County, TN	17,442	17,812	3,571	3,524	13,871	14,288	3,680	4,134	10,191	10,154
Coffee County, TN	55,932	57,865	13,140	13,331	42,792	44,534	10,225	11,573	32,567	32,961
Cumberland County, TN	61,910	65,575	10,702	10,767	51,208	54,808	19,871	23,106	31,337	31,702
Franklin County, TN	42,097	42,681	8,610	8,158	33,487	34,523	8,752	9,972	24,735	24,551
Loudon County, TN	54,261	57,923	10,069	10,311	44,192	47,612	15,089	17,908	29,103	29,704
Monroe County, TN	47,980	50,062	10,186	10,083	37,794	39,979	10,398	12,384	27,396	27,595
Roane County, TN	55,630	56,301	10,683	10,324	44,947	45,977	12,670	14,509	32,277	31,468
Van Buren County, TN	5,651	5,686	1,056	992	4,595	4,694	1,313	1,554	3,282	3,140
Warren County, TN	40,872	41,446	9,673	9,537	31,199	31,909	7,350	8,233	23,849	23,676
** → *Total - Tennessee*	1,015,247	1,049,445	215,353	217,133	799,894	832,312	203,262	233,652	596,632	598,660
Dade County, GA	16,480	16,571	3,262	3,118	13,218	13,453	2,889	3,221	10,329	10,232
Walker County, GA	68,154	68,576	15,052	14,548	53,102	54,028	11,988	13,424	41,114	40,604
Catoosa County, GA	66,244	68,063	15,258	14,909	50,986	53,154	10,789	12,212	40,197	40,942
DeKalb County, AL	70,940	71,111	17,601	17,268	53,339	53,843	11,494	12,596	41,845	41,247
Jackson County, AL	52,763	52,717	11,212	10,768	41,551	41,949	10,220	11,288	31,331	30,661
Chatooga County, GA	24,450	23,811	5,419	5,168	19,031	18,643	4,157	4,459	14,874	14,184
Fannin County, GA	24,131	24,727	4,311	4,263	19,820	20,464	6,155	6,823	13,665	13,641
Gilmer County, GA	29,086	29,911	6,041	6,048	23,045	23,863	6,372	7,148	16,673	16,715
Gordon County, GA	56,214	57,299	14,354	14,197	41,860	43,102	7,781	8,801	34,079	34,301
Murray County, GA	39,229	39,724	10,001	10,020	29,228	29,704	5,300	5,989	23,928	23,715
Whitfield County, GA	103,211	104,465	28,274	27,927	74,937	76,538	13,297	14,593	61,640	61,945
Cherokee County, NC	27,512	27,844	4,842	4,694	22,670	23,150	7,364	8,032	15,306	15,118
** → *Total - Out Of State*	578,414	584,819	135,627	132,928	442,787	451,891	97,806	108,586	344,981	343,305
Grand Total	1,593,661	1,634,264	350,980	350,061	1,242,681	1,284,203	301,068	342,238	941,613	941,965